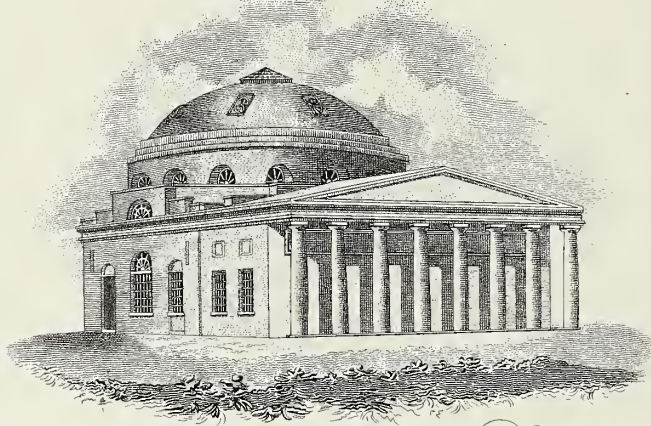


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INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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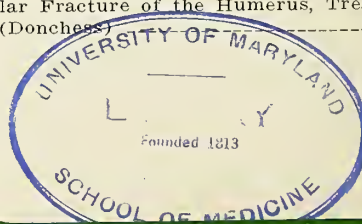
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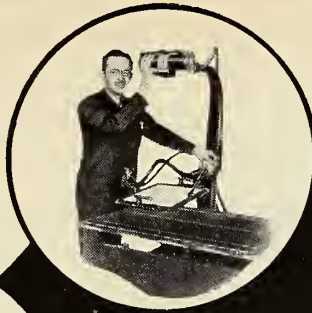
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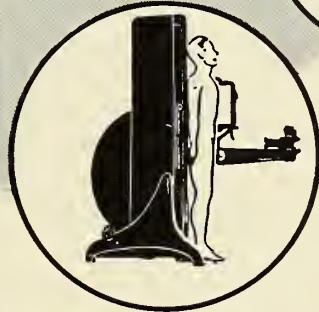
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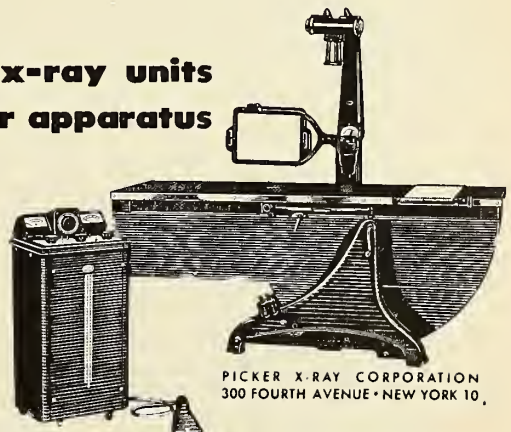
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DISABILITY EVALUATION†

DEFINITION OF DISABILITY

EARL D. McBRIDE, M.D.‡

OKLAHOMA CITY, OKLAHOMA

DISABILITY means a lessening of the normal ability of the body to perform useful functions of work. The word "disability" implies that a transformation of the body structures has taken place which results in a lowered ability of the body to perform functions of established physical accomplishments.*



ETIOLOGY OF DISABILITY

Disability of the body may occur from injury, disease, new growth, or malformation. Any one of these four causes may produce destruction of body tissue, permanent deformity, ankylosis or other physical impairment, which may prevent the body from performing its normal, useful function. Normal body physique designed through heritage may be developed to different degrees through environmental influences throughout life. The body is constantly reacting toward the forces of gravity and inertia. Consequently, these reactions carried out day after day, at work or play, establish habitual automatic and purposeful movements, and functions which determine function and form of the body. When functions are performed and repeated often enough the individual becomes skillful and the accomplish-

ments are then said to be that of an expert. These reactions may be affected by the constant adjustment of the body structures, through reflex and voluntary stimuli which are necessary to create the mental and physical activities of life. Man's whole body records his emotions and manner of reasoning. Sudden interruption of body functions through disease or injury calls for a new role of neuromuscular and emotional mechanism. Disability can be overcome only if the intelligence and ambitions of the affected individual can defeat discouragement and inspire determined adjustment toward rehabilitation.

MECHANICAL EFFECTS ON ALTERED BODY STRUCTURES

When the original biologic form of the body is altered in shape, size, length, volume or range of action, the diversion of forces involves mathematical problems of physics and geometry, as well as physiology.

Actually in order to be an expert in examining and analyzing the disability of a person, much more should be known than that revealed grossly by the ordinary physical examination. The shafts of bones are obedient to muscular dominance. The structural forms provide advantageous contours and appropriate joints for receiving the forces of stress which promote equilibrium, kinetic acceleration, coordination and power. When the injury has altered these forms and disturbed stability there is a relative diversion of the animated forces of weight, gravity and muscular power, which creates a demand for new training and increased energy. For instance, the shoulder, which might be called

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the steering wheel of the arm, may become ankylosed at this side and thus restrict movement to the elbow, wrist and hand, which must act only in the sagittal plane of the body. There is no longer the accommodation to reach into various directions. Likewise, the ankle joint, which provides spring-like resilience to the foot, when ankylosed simplifies the mechanics of the foot and leg action, comparable to a rigid base and pedestal. The back or trunk of the body, which through muscular action greatly simulates the physics of the derrick or crane, may lose flexibility through stiffness and pain so that the stresses and accommodation for lifting are shifted to the hips, knees and ankles, causing the person to squat when ordinarily he would freely flex his back. Misalignment of bone shafts may displace the normal position of the joint axes and result in movements away from the normal plane. Anatomic angulation of a bone shaft may cause a disturbance of the forces of stress throughout the columnar length of the bone, thereby disorganizing the associated structures acting upon this shaft.

REHABILITATION AND ADJUSTMENT

When a disability of the body is of a partial, permanent nature, it is implied that there remains a certain capacity for work beyond the limitation of the physical handicap. Readjustment of the disabled person to the field of labor involves readjustment factors of intricate proportions and multiple variations. The extent to which the individual will be limited will depend on the complex influences incorporated within the mind and body of the person, as well as the social and economic opportunities encountered in the environment of competition.

THE DOCTOR AS AN EXPERT WITNESS

The one and only object of the doctor on the witness stand is to give the trier of the facts a clear and convincing picture of that which is in the witness's mind. Even under the most favorable circumstances, outside of court, it is often difficult for the doctor to explain an intricate medical problem, even to the highly intelligent layman. Therefore, the doctor on the witness stand must use all his reasoning power and all his tact and common sense to keep his line of thought clear and effective. The expert witness must be nonpartisan. He is sworn to tell the truth, and the fact that he is not prosecuted for perjury does not minimize the seriousness of any deviation. It is not unusual or wrong for doctors who are conscientious and competent to disagree. This occurs constantly in the professional career. However, no doctor has a right as an expert witness to barter his opinion for the sake of making a favorable impression upon one side or the other, whichever may be expecting such favor.

EXAMINATIONS AND REPORTS

Thoroughness is the watchword and test of sincerity in preparing full information pertaining to

a case of personal injury. Details of observation are important. All physical defects other than those caused by the present injury should be observed, examined and recorded. Inquiry should be made into the past history relative to previous accidents and disabilities. Seemingly unimportant oversights, omissions or inconsistencies may give rise to embarrassment on the witness stand when cross-examination is undertaken.

The medical industrial nature of the disability should be carefully traced to the original injury. Exact details of the accidental event should be insisted upon. The severity of the attendant circumstances, the extent and seriousness of immediate disability, the treatment and the course of the recovery should be elicited. The duration of the initial, and any subsequent period of total incapacity, especially periods reflecting delayed union, inflammation, swelling, drainage or operative intervention should be given consideration.

PREEXISTING PHYSICAL DEFECTS

Physical defects and anatomic variations are common to all individuals and may not be known or previously recognized. Consequently, congenital abnormalities or defects due to childhood diseases, such as variation in posture, asymmetry of anatomic parts, defects of vision, may be used to build up the magnitude of the pathology claimed to be causing the disability.

STANDARDIZING THE MEASUREMENT OF DISABILITY

Industrial compensation awards are usually based on amputation values established by law. When the part is not amputated but is partially disabled, the disability is said to be a partial loss and there is no schedule for partial disability. This loss can be determined through medical opinion. Numerous difficulties have been encountered in establishing standards of evaluating the percentage of partial, permanent disability. There is no place for human sympathy or emotional persuasion in this process of measuring liability. It is not expected that medical opinion should agree but it is expected that sound scientific reasoning be employed as based upon medical knowledge and training.

The extent of disability cannot be measured by vocational loss. It may not cause change of occupation or wage loss in that occupation. It cannot be based on anatomic or structural losses although most statutes group the evaluations around crudely calculated losses such as amputations. However, if the law has fixed an amputation value then partial disability is but a percent of such value. The provisions of the statutes are intended to compensate for the loss of wage earning capacity but the method of evaluating disability, as applied through medical opinion, cannot be based on the economic capacity of the individual; it must be based on function.

LOSS OF FUNCTION THE BASIS OF DISABILITY

There is only one common ground upon which medical analysis of a physical handicap may stand, and that is the analysis of function. That is, it must be determined what the individual can or cannot do as a result of the disability. When this answer is arrived at, the industrial court may interpret the influence of such percentages of function loss in terms of wage earning loss. The coefficient of work is function. The quotient of disability must be found through a common denominator of occupation, trade or vocation. If the disability is evaluated specifically for the carpentering trade, the activities required of a carpenter must be weighed and tested. Such a rating would naturally be higher than for ordinary manual labor.

HOW SHALL FUNCTION BE MEASURED

The analysis of what is meant by the function of the organism reveals the following factors which make possible such acts as those of lifting, pulling, bending, turning, pushing, walking, jumping, running, grasping or throwing.

1. Quickness of action.
2. Coordination of movements.
3. Strength.
4. Security.
5. Endurance.

In respect to industrial injuries two other factors should be added, i.e.:

6. Safety as a workman.
7. Prestige of physique in securing employment.

It is reasonable that each of these functional factors should bear its relation to the evaluated loss. No single factor alone is responsible for the disability. For instance, if the disabled member has only 50 percent strength, it does not follow that losses in other factors are the same. If each factor, therefore, is given a percentage evaluation according to its relative importance to the working capacity, then there will be a basis upon which to establish a suitable measuring rod of disability.

The relative value of each functional factor in respect to 100 percent may be as follows:

1. Quickness of action.....	10 percent.
2. Coordination	20 percent.
3. Strength	20 percent.
4. Security	10 percent.
5. Endurance	20 percent.
6. Safety as a workman.....	10 percent.
7. Prestige of physique.....	10 percent.
Total	100 percent.

When the physical examination has thoroughly revealed whatever physiologic and anatomic deficiencies may have resulted from the injury, the effect on each functional factor may be estimated as a percentage of loss in respect to that particular capacity. The total of these percentages of loss

will represent the partial loss of the part as a whole.

For example, in case motion is limited in the elbow from 180° extension to 90° flexion, the analysis of disability would be as follows, with, of course, variations of opinion:

Delayed action	25% of 10 or 2.5
Awkwardness	25% of 20 or 5.0
Weakness	15% of 20 or 3.0
Insecurity	15% of 10 or 1.5
Diminished endurance	15% of 20 or 3.0
Increased risk	10% of 10 or 1.0
Lessened employability	15% of 10 or 1.5

Percentage disability to arm..... 17.5

These mathematical formulae demonstrate how evaluation of disability may be standardized. The law provides specific awards for definite disabilities, such as amputation of the extremities at different levels. Therefore, when the extremity is disabled but not amputated, the doctor is called upon to express the partial disability in percentage. Since amputation represents 100 percent loss, a partial loss is a matter of comparison to this total loss, expressed in percentage.

It is also necessary to be able to determine the relative percentage of disability of the various parts of the body. If an arm is disabled it is necessary to know how to express the percentage loss to the body as well as to the arm. For instance, the specific award for amputation of an arm may be 250 weeks, while permanent disability to the body as a whole may be specified at 500 weeks. The relation of the arm to the body as a whole is therefore 50:100. A 20 percent disability to the arm would be equal to 10 percent disability to the body as a whole. If the value of amputation of the index finger is 35 weeks and the arm below the elbow has a value of 200 weeks, then the relative value of the index finger to the arm below the elbow would be 17.5 percent.

Other calculations are necessary when there are multiple disabilities to the extremity. For example, if we should have several injuries to an arm, such as an ulnar nerve paralysis, that would in itself be a 60 percent loss of the arm, a loss to the thumb that would be 10 percent, loss to the arm, and a loss due to stiffness of the elbow that would be 50 percent; the total of these disabilities would be 120 percent, or 20 percent more than 100. A convenient mathematical calculation for multiple disabilities of this kind would be as follows:

One hundred percent, less 60 percent disability, would leave a balance of 40 percent, upon which to calculate further disability. Ten percent of the 40 percent is 4 percent, which is credited to the thumb disability. Forty percent minus 4, leaves 36 percent balance upon which to calculate the third disability of 50 percent. Fifty percent of 36 is 18 percent, which is the loss credited to the elbow. The sum of 60, 4 and 18 gives a total of 82 percent. Therefore, 82 percent would be the total loss, rather than 120 percent.

CONCLUSION

The doctor who is willing to examine industrial cases and testify in court, where he will be called upon to evaluate disability, should make a special study of this subject. Since the subject is not

taught in medical schools he must seek special information on the subject until he has mastered it the same as he has mastered his scientific subjects. He will then find this field of practice very pleasant and satisfactory.

THE CUTANEOUS TOXICITY OF DIHYDROXYDICHLORDIPHENYLMETHANE A NEW FUNGICIDE FOR ATHLETE'S FOOT

L. EDWARD GAUL, M.D.

G. B. UNDERWOOD, M.D.

EVANSVILLE

THE patient, H. H., a white male, aged 34, a salesman, sat in the consultation room. His feet were on a stool to help ease them. The look on his face told of trouble. Nearby was his cane. His slippers had had the vamp cut away to make more room for his feet. On an old newspaper was a heap of soiled dressings. The story that this patient told is heard daily.

Present Illness. Early in June, 1947, and during a hot spell, he observed that the dorsal surface of the first and second right toes and the second left toe had broken out with many little water blisters that itched like mad. This was self-diagnosed athlete's foot from reading lay advertising. He tried Mennen's Skin Bracer, Ammen's Antiseptic Pow-

der, and Ting. The dermatitis remained stubborn. The morning of July 22, 1947, he read an advertisement in a Chicago newspaper about "a new 24 hour treatment that gives 5-way protection with a no risk test or your money back." He hastened to the drugstore to buy this amazing war discovery, Vodisan and Vodust, containing dihydroxydichlordiphenylmethane. The directions for treatment were followed. He was not disheartened by failing to obtain the promised cure in 24 hours. His was a stubborn case; the fungi were probably tough and would take longer to kill. By Sunday evening, August 3, 1947, the dermatitis had spread to the ankles. The ointment was applied liberally that night. Monday morning his feet were

Figure I



Patch test to Vodisan Ointment which became positive within 48 hours.

Figure II



Shows the intensity of the reaction to Vodisan Ointment (72 hours) and above this the reaction to the Vodust Powder which appeared in 60 hours. Both of these reactions were present at the end of 10 days.

Figure III



The dissected shoes. The one to the right contained materials that were irritants or sensitizers.

so swollen that he could not get his shoes on, nor would they bear his full weight. He was horrified that the fungus had spread further, in fact, almost to the knees. For the first time he considered it necessary to call a physician.

Dermatologic Examination. This was not remarkable except for the legs and feet. The ankles to the margin of the soles, including the dorsal and interdigital aspects of the toes, presented an acute erythrodermia. A two-plus pitting edema was present. Over the toes and distal portion of the feet were many erosions, whose greatest diameter was about 4 millimeters. Vesiculation was beginning with coalescence to form weeping patches. Adenopathy was not palpable in the popliteal or inguinal regions. The anterior lower two-thirds of the legs showed an id eruption with slight erythema. Symptoms were severe over the legs but absent on the feet. The soles and flexor aspect of the toes were not involved. A physical examination revealed nothing unusual. The blood pressure was 130/70, the temperature 98.9 F., and the pulse rate 74. The past history disclosed a tonsillectomy 20 years ago. While in the South Pacific, he had eight carbuncles which healed uneventfully. Ten years ago he was bothered with athlete's foot for two weeks. A family and personal history for atopy and venenatas was negative.

Laboratory Examinations. A complete blood count and urinalysis were normal. The serology was negative. Scrapings from between the toes

and the roofs of vesicles did not show mycelium or chains of spores. Attempts to find fungi were made on three successive days. Cultures from the toes and vesicles, repeated after four days, did not show any growth in two weeks.

Patch Test Investigations. The past-treatment patch tests were done with Vodust powder, Vodisan Ointment, Mennen's Skin Bracer, Ammen's Powder, Ting, and for screening ethylaminobenzoate 5 percent in petrolatum, mercuric chloride aqueous 1:1,000, merthiolate aqueous 1:1,000, and boric acid powder. Forty-eight hours later, all were negative except Vodisan Ointment, which showed a bright erythema with edema. It was ringed with ink and photographed. (Figure I.) The area of testing was cleaned with ether and the patient asked to return in 24 hours. A reaction appeared to the Vodust Powder in twelve hours. It was ringed with ink and photographed. (Figure II.) The boric acid in the Vodust Powder was patch-test negative so the dihydroxydichlordiphenylmethane was considered the offender.

This investigation would not be complete until the footwear had been tested. Two pairs of shoes and what was left of the slippers represented all the footwear worn the past year. The white socks were not tested. The shoes and slippers were caked on the inside with foot powders. Samples were removed and these gave positive patch tests in 48 hours. The reactions duplicated the reactions to Vodust Ointment. This made the footwear unsafe

and permission was obtained to dissect the shoes. The right shoe of each pair is shown in Figure III. Upon opening the shoes, it was noted that the inner cloth lining had been worn through by those toes which showed the initial dermatitis. Also, these were the toes that wore through the socks. The powder was brushed off and samples cut out for patch tests. The samples from the slippers and the shoe to the left (Figure III) were negative. Samples from the other shoe, the toe box reinforcing cap—a rubber or asphalt material that had been rubbed thin from friction with the toes—a rubber adhesive surface of the cloth lining, a coated or impregnated fabric, and the insole packing produced positive patch tests. The reactions did not appear until the testing area was exposed to air. Intense itching developed with the onset of the reactions. The erythema was moderate and a fine vesiculation was apparent at the edges of the samples. The toe cap showed, in addition, a diffuse vesiculation with perceptible edema. The reaction to the adhesive tape was moderate. Patients who complain of their feet itching on removing their shoes at night should have patch tests performed with the shoes. Footwear is a common cause of the lay diagnosis, athlete's foot.¹

¹ Gaul, L. E., Underwood, G. B.: Primarily Irritating and Sensitizing Materials Used in the Fabrication of Civilian and Military Footwear. *Arch. Derm. & Syph.* (In Press).

Final Diagnosis. Case H. H. had dermatitis contact of the feet from materials in a pair of shoes. It had been complicated by a fungicide. This diagnosis was proven correct because the institution of care and management² brought about a prompt involution.

COMMENTS

The incubation period of dihydroxydichloridiphenylmethane in our patient was 12 days. During this interval the dermatitis remained indolent. It seemed to be getting better. When the incubation period had been satisfied, the dermatitis suddenly spread from the initial location with violent signs. Simultaneously, id lesions appeared on the legs. Patch tests on the arm were positive, indicating that a generalized sensitization had occurred. Recently a patient was observed with a generalized, patchy, vesicular eczemization. After the dermatitis had cleared, a patch test with Watkins Unguent was strongly positive. To our surprise, this proprietary, too, contained dihydroxydichloridiphenylmethane. This patient was additional proof that this chemical is a powerful sensitizer.

² Underwood, G. B., Gaul, L. E.: Overtreatment Dermatitis in Dermatitis Venenata Due to Plants. *J.A.M.A.* Vol. 138, p. 570. Oct. 23, 1948.

PREGNANCY AND THE Rh FACTOR

EDITH L. POTTER, M.D.*

CHICAGO

THE Rh factor has received a surprising amount of publicity in the short time that has elapsed since its discovery, and many people have come to the conclusion that far too much has been heard of it. Many excellent papers have been written in the last few years, but others, based on inadequate experimental or clinical material, have often expressed views that were not adequately substantiated by the data presented.

It is only because of this flood of publications that the subject seems complicated. Actually the fundamental concept is very simple. It is based on two facts: one, that the human body will produce antibodies in response to the introduction of certain foreign materials and, two, that human red blood cells, like those of most animals, have varying types of antigenic substances attached to them. The first of these substances to be discovered were recognized by Landstamier in 1900 and

by him were designated A and B. If the blood cells of any individual lack A or B, the blood serum contains naturally occurring antibodies that will cause agglutination of cells containing the missing substance. Human cells may also have attached substances known as M, N and P, or any of these may be missing. These differ from A and B inasmuch as antibodies against them are not a normal constituent of the body, nor are they ordinarily produced when cells containing these substances are introduced into the circulation.

The Rh is another substance, some form of which is present in the cells of about 87 percent of the Caucasian race and absent from about 13 percent. Rh is a general name and includes at least 3 subgroups, only one of which is common. These subgroups rarely occur singly but are usually found in combination, and one particular member of the combination is present in almost 85 out of the 87 percent. This one is known specifically as Rh₀, and it is ordinarily this subgroup that is meant when cells are designated as Rh-positive or Rh-negative.

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Naturally occurring antibodies against Rh have been observed very rarely (and in this respect it is like M, N and P), but they may be formed if Rh-positive cells are introduced into the circulation of susceptible Rh-negative individuals (and in this regard it is more similar to A and B, antibodies against which can be increased by the introduction of cells containing either one of these substances into the blood stream of a person in whom they are lacking.)

Diamond and other investigators who have attempted to immunize groups of Rh-negative men to the Rh factor have been successful in only about half of their subjects. As individuals vary in their ability to develop antibodies against bacteria and other foreign proteins, so they vary in regard to Rh. It seems probable that about half of all individuals, both men and women, are resistant to Rh and cannot ordinarily become immunized to it.

In the male population immunization can be brought about in only one way: by the introduction of Rh-positive blood into the circulation. In the female population it can occur in two ways: by ordinary transfusion, as in the male, and by the occult transfusions caused by the escape of Rh-positive fetal cells from the vessels in the villi of the placenta.

If Rh-positive cells do gain access to the circulation and do stimulate antibody production, the immunization thus produced is permanent. Although demonstrable antibodies may disappear from the blood they will still make themselves manifest if even minute amounts of Rh-positive blood are again introduced. When a woman who has been immunized conceives an Rh-positive child, the antibodies in her blood stream will pass through the walls of the villi, enter the fetal circulation and combine with the Rh-positive cells of the fetus, causing part of them to be agglutinated and hemolyzed. An antigen-antibody equilibrium is established, the amount of cell destruction being related to the amount and variety of antibody present.

Two varieties of antibodies are recognized, one generally known as a saline agglutinating antibody, the other as a hyperimmune or blocking antibody. Both, however, can be demonstrated as agglutinating antibodies by appropriate methods and both appear to act as hemolysins within the body. The so-called saline agglutinating antibodies ordinarily appear early in the course of immunization; hyperimmune antibodies are demonstrable only after more prolonged immunization. The presence of the latter form of antibody usually indicates a high degree of immunization, and such antibodies often appear to exert a more harmful influence on the fetus than do saline agglutinating antibodies.

Since it has been proved that erythroblastosis fetalis, or congenital hemolytic disease, as it has

also been called in recent years, is a result of maternal immunization to Rh, the problem immediately arises as to the outlook for pregnancy in any woman who is found to be Rh-negative.

Approximately 15 percent of all women are negative to the common anti-Rh_o serum. Of these, about 15 percent can be expected to have Rh-negative husbands. It has been calculated that about 42 percent of all Rh-positive individuals are homozygous and 58 percent heterozygous. All of the children of a homozygous man will be Rh-positive, but in general only half of those of a heterozygous man will be Rh-positive. A group of Rh-negative women married to a random selection of Rh-positive men can expect about 29 percent of their children to be Rh-negative. Consequently about 8.3 percent of all pregnancies are in Rh-negative women bearing Rh-positive children.

Erythroblastosis almost never occurs in a first child unless the mother has had a previous blood transfusion or an abortion, and slightly less than half of all pregnancies occur in primigravidae women. Therefore, about 5 percent of all pregnancies are in multigravidae Rh-negative women bearing Rh-positive children. We could consequently anticipate that if every Rh-negative woman conceiving an Rh-positive child in a second or subsequent pregnancy gave birth to an infant with erythroblastosis, about one in every 20 children born would be affected.

What percentage of children do have erythroblastosis? The number is very hard to calculate, but there are a few studies that yield some information. We have now studied over 160 fetuses and infants with this disease at the Chicago Lying-in Hospital. About two-thirds of these were born in this hospital. Forty-five infants survived, 44 were born alive but died, and about 62 were stillborn. This investigation was begun in 1934, but until 1941 the diagnosis was made very infrequently on surviving infants. As a result, it is highly probable that the incidence of survivors is too low and that if the same rates held prior to 1941 as have been observed since then we would have almost the same number of infants surviving as died or were stillborn.

It seems probable, from the many studies that have been made, that immunization ordinarily takes place before the beginning of the pregnancy in which the disease is found, and that immunization has been initiated before conception occurs.

Among the 160 infants with this disease in The Chicago Lying-in Hospital series of cases, only three were the offspring of primiparous mothers who were without a history of transfusion or abortion, and all three had a very mild form of the disease.

Since the disease so rarely occurs in a severe form in a first pregnancy it must be assumed that this is due to one of two things: either leakage

of fetal cells from the placenta into the maternal circulation cannot induce immunization severe enough to harm the fetus during the course of the pregnancy in which it first takes place; or immunization is associated with the processes of labor or delivery and has been initiated during the birth of an older child.

We have observed a higher incidence of long and complicated labors, cesarean section, manual removal of the placenta and other complications in women giving birth to infants with erythroblastosis than would be expected in a group of normal unselected women. All of these conditions would increase the hazard of rupture of fetal vessels and promote the entrance of fetal cells into the maternal circulation.

Transfusions are a well-recognized method of producing immunization. Abortions, especially those brought about by intrauterine manipulations, are also conducive to rupture of fetal blood vessels. In our series, 30 percent of the women giving birth to infants with erythroblastosis had had one or more transfusions or abortions, either between the birth of the last normal child and the first one with erythroblastosis, or before the birth of the first child if it was affected by this condition.

In the five years from 1941 to 1946 during the course of 17,500 deliveries in our hospital, erythroblastosis was responsible for 2.5 deaths per 1,000 births, and was exceeded only by malformations in the specific causes responsible for death in the newborn period. Sterility and habitual abortions have never been shown to be caused by Rh immunization.

Since erythroblastosis is a condition which has become recognized as one of the most important pathologic conditions responsible for failure of an infant to survive, what plan is to be pursued in an attempt to reduce this mortality?

Valuable information can be obtained by determining the Rh status of all patients. It is our practice at present to use slide testing with high titered human serum, a method which takes only about one minute, and to check the bloods which seem negative with another serum, using the test-tube incubation technic. The choice of the method is less important than the ability of the technician to perform accurately whatever method is being used. The greatest likelihood of error lies in an unrecognized deterioration of the serum and in reading the tests. Every technician should be specially trained before being permitted to give a final report. The examination is made on the patient's first prenatal visit and if found to be Rh-negative, she is given a card on her next visit requesting that her husband appear for testing, and a printed sheet of paper explaining briefly what Rh means.

It has been suggested that to tell a woman she is Rh-negative causes needless worry and that

it would be better for her not to know. This is probably true to some extent, but since Rh has had so much publicity a large share of patients are aware of it, and it cannot be ignored. It is also well for a patient to know she is Rh-negative in the possibility that she may need a transfusion at some later date.

Is it necessary to perform antibody determinations on all Rh-negative women?

During the past two years we have made antibody determinations on the plasma of the majority of patients found to be Rh-negative, using the same specimen as that drawn for the original Rh determination. For this also we have employed a slide method, one which Diamond has found highly satisfactory in determining the presence of either the saline or albumin agglutinating antibodies. This also takes only about a minute; if antibodies are demonstrated by this method, further studies to determine their concentration and variety are made, using the test tube technic. If antibodies are not present on the first examination the tests are not repeated unless the patient has had an abortion or lost a child in an earlier pregnancy. It seems probable that unless antibodies are present early in pregnancy they will rarely be found later in sufficient concentration to injure the fetus. During the past year we have studied the blood of over 600 pregnant Rh-negative women and have found antibodies in 14. In 10 of these there was a history of previous transfusions, stillbirth or infant death, or a pregnancy known to have terminated in the birth of an infant with erythroblastosis. In only 4 was there no suspicion prior to antibody determination that immunization might have occurred. The outcome of pregnancy in one of these four patients is not known; two had infants with mild erythroblastosis, and one lost a child from this condition. In no patient who failed to have demonstrable antibodies did erythroblastosis appear in the infant.

We believe, at present, that it is important to question closely all Rh-negative patients concerning previous transfusions, abortions, stillbirths and infant deaths, and that if a history of any of these is obtained it is imperative to attempt the demonstration of antibodies in the maternal blood. Infants of Rh-negative mothers may die from the same causes as those of Rh-positive mothers, and death may be entirely unrelated to the fact that the mother is Rh-negative. Nevertheless, the blood of any woman with a history of a transfusion or an unsuccessful pregnancy should be very carefully examined. In the absence of such a history, routine testing for the presence of antibodies becomes one of the refinements of obstetric practice, but one which is not of great immediate significance in the management of the patient. If a patient has not lost a child earlier nor had a transfusion, there is practically never any indication for a modification of the method of delivery nor for a change in the immediate postnatal care of the infant.

If antibodies are found in a patient with such a history, the infant of the existing pregnancy is almost certain to have erythroblastosis. May it possibly be Rh-negative and thus escape the disease? Very infrequently. Race and his co-workers in England have found almost no Rh-negative children among those whose older sibling or siblings had erythroblastosis; and among 132 infants in our series who were delivered after their mothers had each given birth to an infant with this condition in an earlier pregnancy, only 4 were Rh-negative instead of the expected 29. There appears to be some relation between the homozygous Rh-positive state in the father and the occurrence of the disease in the child. Rh-negative children are infrequently found among the offspring of a woman who has once had an infant with erythroblastosis.

If a diagnosis of erythroblastosis seems fairly certain the question arises as to whether early delivery is advisable. We have not been impressed with the value of this procedure, either from our own experience or from the data reported by other investigators. If a woman has lost her last child from erythroblastosis there seems little to lose by early delivery, but neither does there seem much to gain. We have rarely succeeded in giving a mother a normal living infant by this procedure if her last child had died of proven erythroblastosis. If early delivery is contemplated, cesarean section is generally preferable to induction from below. This is because of the high incidence of long and complicated labors and deliveries, and the higher infant mortality that is attendant upon induction in the presence of an unripe cervix; such a labor is also associated with an increased possibility of the introduction of fetal cells into the circulation and a resultant increase in maternal immunization.

The children of all Rh-negative mothers should be very carefully examined immediately after birth and should be carefully observed during their entire hospital stay. In our nurseries the cribs of all infants of Rh-negative mothers are marked with large orange cards so that the nurses and medical attendants are kept constantly aware of these babies.

All infants who appear normal on physical examination are subjected to blood studies on the first or second day and again on the eighth day of life. The first examination includes an Rh determination, hemoglobin, erythrocyte and differential count. The eighth day examination includes only a hemoglobin and erythrocyte count.

An infant who develops early jaundice, subepidermal hemorrhage, or who has an enlarged spleen is studied more intensively and is treated with blood transfusions if anemia develops.

Are transfusions given immediately when a diagnosis of erythroblastosis is made? No. Only if the degree of anemia warrants. In the first few days of life a level of 3,000,000 cells is generally

considered an indication for transfusion. In an infant 10 days or more of age, levels of 2,500,000 cells per cubic millimeter or even lower may be tolerated. The smaller the amount of blood that it is necessary to give, the better the final outlook for the infant seems to be. All evidence is in favor of the use of Rh-negative blood.

Are "exsanguination" or "exchange" transfusions desirable? Too little evidence is yet available to know for certain, but they seem at times to give better results than the ordinary transfusion. Diamond, Wiener, Wallerstein and others have reported excellent results, and in our hands, too, the infants seem to have benefited more greatly than by multiple transfusions given at varying intervals after birth.

If an infant survives the neonatal period, will it have recurrences of the disease, and will it be mentally handicapped? At the age of 4 to 6 weeks an infant who has been severely affected not infrequently needs further transfusion, owing probably to the gradual destruction of cells that have been given in the earlier transfusions and the persistence of a hypoplastic phase in his own hematopoiesis. Fewer than 10 percent of the surviving infants, both in our own series and those reported by other investigators, give evidence of permanent brain damage.

Is a woman once immunized henceforth unable to give birth to normal children or may she have normal children if a few years are allowed to elapse after the birth of a child with erythroblastosis and especially if antibodies disappear from her blood? The passage of time seems to make no difference, and a woman once immunized, even though antibodies become nondemonstrable in her blood, appears almost invariably to give birth to infants with erythroblastosis in all subsequent pregnancies providing such infants are Rh-positive. Artificial insemination with Rh-negative sperm or remarriage to an Rh-negative husband will ensure her children who are free of the disease because they will be Rh-negative. No method of desensitization has been found. As a consequence, all women who have given birth to an infant with erythroblastosis, especially if the disease was severe enough to have caused death, should be advised against further pregnancies.

Can immunization be prevented? One important way of eliminating one source of immunization is by never transfusing any female during or prior to the childbearing age without first determining her Rh status and giving only Rh-negative blood if she is Rh-negative. There are several women in our series, and other investigators have recorded many more, who have been denied the privilege of ever bearing a normal infant because of transfusions given in girlhood. An Rh determination should be part of the pretransfusion examination of every patient, and all blood to be used for transfusion should be classified as to its Rh type. In

this way Rh-negative blood is not wasted on Rh-positive patients but is available when needed. To give blood, the Rh status of which is not known, to a woman who is already immunized may be the same as signing her death certificate.

A second way of preventing immunization is to make more widely known the fact that the mechanical trauma associated with the intentional production of an abortion may be a cause of immunization. Fewer abortions would be contemplated if women realized that the initiation of an abortion might make the bearing of a normal child impossible.

A third way is by a careful conduct of labor aimed at reducing as far as possible the situations which are conducive to the disruption of fetal blood vessels.

Although the processes known to contribute to immunization may be eliminated, it is still not possible to prevent the leakage of cells which apparently may occur in any pregnancy and which may thus prepare the ground for the development of erythroblastosis in the next offspring.

SUMMARY

It has been shown that about 15 percent of all women are Rh-negative but that only about two-thirds of these (10 percent of all women) are married to Rh-positive men and bearing Rh-positive children. Erythroblastosis occurs in only .5 to .8 percent of all pregnancies, or the children of only one in 25 to 30 Rh-negative women. Part of these children will die or be stillborn, and about 10 percent of those who survive will be partially paralyzed, athetotic and mentally retarded. Treatment consists in the administration of Rh-negative blood in amounts indicated by the degree of anemia. No mother who has given birth to an infant with this

condition should ever be transfused with Rh-positive blood.

It seems advisable to perform antenatal Rh determinations on all pregnant women and to test for antibodies all women who are found Rh-negative. If antibodies are not present early in pregnancy there is little likelihood that the infant will suffer from erythroblastosis, but as a special precaution, the cribs of all children of Rh-negative mothers should be marked and all such children should have blood studies soon after birth and again before discharge from the hospital. Unless affected by erythroblastosis, infants of Rh-negative mothers are no different from those of Rh-positive mothers. The fact that a woman is Rh-negative is not responsible for abortion or sterility.

There is no way of reducing the degree of immunization of the mother or preventing the development of erythroblastosis in the Rh-positive children of a woman who has once been immunized. Artificial insemination with serum from an Rh-negative donor will ensure the birth of an Rh-negative child who will not be affected by the disease.

The initiation of immunization may be prevented in some instances by avoiding transfusion with Rh-positive blood, preventing intentional abortions, and by the careful management of labor. Immunization seems almost always to be begun at some time prior to the first pregnancy in which the disease appears in the child, and it is to these earlier situations that particular attention must be paid.

All women (and men as well) of any age should have the Rh status determined before receiving a transfusion, and if Rh-negative, should be given only Rh-negative blood. This is to prevent the initiation of immunization in the nonimmunized individual and to prevent a hemolytic reaction in the individual who may have been immunized.

PHYSICIAN'S CREED

In accepting the A.M.A.'s medal "for exceptional service by a general practitioner" at the interim session in St. Louis, Dr. W. L. Pressly, of Due West, South Carolina, said:

"In entering the field of general practice, I resolved and have sought rigidly to adhere to the one idea that my life would be one of service, regardless of any other influence that might come to bear upon it. Those 33 years, during which I have endeavored to hold to this ideal, have been full of joy.

"I am sure this is the desire and ideal of the 100,000 or more general practitioners in our Association. Hence I regard this honor, not as one to me personally, but to me as representing those men and the ideal which we hold dear.

"May it ever be that the thought of service to humanity, in the spirit of the Great Physician, shall never lose its appeal and its controlling motive."

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

Editorials

MEDICAL PUBLIC RELATIONS

PUBLIC relations programs were originally undertaken by large corporations because the detached and impersonal nature of their business activities had led to ill will and widespread public misunderstanding. The technic of creating good will in such a situation is largely related to advertising. It consists mainly of an informational or educational campaign which seeks to acquaint the public with the "human" side of the industry in question. It achieves its ends by emphasizing contributions of the corporation to the public benefit. Public relations, in an instance such as this, seeks to offset the disadvantages inherent in a large impersonal operation, by acquainting the general public with the details of its activities and with the advantages which accrue to society as a result thereof.

Public relations activities for the medical profession are not necessary for the above reasons.

Instead of being a detached and impersonal transaction, the practice of medicine is quite the opposite. Each individual practicing physician has each day more effective contact with the public than does the most energetic public relations expert. Each individual doctor leaves with his patients an impression, either for good or for bad, which cannot be undone by the most skillful press releases.

The advancement of good will for the medical profession cannot be accomplished by public relations counselors, nor by educational campaigns. As has been said before: "Each doctor is chairman of his Public Relations Committee."

Medicine does need to employ some of the technics of corporate public relations. Publications for the information of the general public on such subjects as control of cancer, advantages of periodic physical examinations, and recent advances in

medicine, are necessary. However, the maintenance of public confidence and good will does not depend on this part of our program. Public esteem of the medical profession was built up in the past and will be maintained in the future by the careful and conscientious performance of our daily tasks, and by adherence on the part of each one of us to the traditions of medical practice.

Instances in which the profession has incurred criticism have naturally been few and far between. If all the laudatory and commendable deeds of physicians received as much publicity as do the occasional censurable items, the bad would be buried under an avalanche of favorable comment. However, bad news travels fast, and a very small minority, by thoughtless or hasty actions, often creates a reaction which reflects on the profession as a whole.

The organization of telephone-answering services, and the provision of lists of physicians available for emergency calls, has been accomplished in many centers by joint action of the doctors and the local hospitals. This means of making medical service available at all times is appreciated by our patients, who, even though they may misjudge the quality of the emergency at times, are grateful for help in time of real or apparent disasters.

Some medical societies have appointed grievance committees to receive, and in some instances to advertise for, complaints. Careful investigation has shown many of the complaints to be unjustifiable, and when they were aired, the complainants themselves sometimes acknowledge their triviality. It is possible that misunderstandings between physicians and their patients may arise from causes such as carelessness, dilatory action, and arrogance on the part of patients and their relatives. It is to the advantage of all that such causes be investigated and judged by a committee of disinterested physicians.

While the medical profession does not require the services of public relations programs of the corporate variety, it can carry on its own kind of public relations through the conscientious practice of medicine. It is blessed with a tremendous volume of good will which serves it well as background for the discussion and correction of occasional shortcomings.

Editorial comments in the lay press, following an address by President Hauss before the annual convention, indicate favorable public reaction toward the recognition of faults on the part of a few doctors, and action by ourselves to secure improvements.

The Kokomo Tribune, on October 28, 1948, commented in part: "The medical profession may gain greatly by recognizing weaknesses within its own structure that could conceivably encourage socialized medicine. If the public knows that it can be sure of getting medical service whenever the need is dire, there would be no public support for socialized medicine."

An editorial in *The Indianapolis Star*, on October 28, 1948, concludes: "The abuses which Dr. Hauss mentions, however, are no argument for socialized medicine. The United States has more conscientious, well-qualified physicians in proportion to its population than any other country in the world. Even if 'misdemeanors and neglects of duty' were widespread the 'cure' would be far worse than the affliction. But there can be no doubt that progressively better service on the part of our free and independent medical profession is the best defense against 'big government' nostrum peddlers."

A LOGICAL CONCLUSION

THE following is from the English journal, *The Lancet*, for October 2, 1948, from the section entitled "Letters to the Editor":

"PRIVATE PATIENTS NOT ADMITTED"

"SIR—In your last issue you take exception to my letter to the *Times* of Sept. 15 in which I uphold the decision of the Minister of Health to exclude private patients from the new health centres because, in my opinion, this is bound to lead to either preferential, more considerate, or better treatment for them. You say—

'The truth seems to be that the great majority of patients remaining as private patients do so in order that they may suit their own convenience as to when, where, and how often, they consult their doctor.'

"But surely if private patients coming to the health centre are permitted to 'suit their convenience' as to when they see their doctor, whereas other patients, except emergencies, have to make appointments between certain hours, they are receiving preferential treatment, and here of course I am using the term treatment to imply service and not medical treatment for disease.

"It is quite permissible to argue that to admit private patients to health centres might have compensating advantages to the doctor or even to the service as a whole by saving the doctor's time, but to deny that it would involve two standards is absurd.

"London, S.W.1.

SOMERVILLE HASTINGS."

Isn't it interesting to see a bureaucratic system indicting itself? Somerville Hastings expresses himself in a naïve fashion regarding the preferential service to private patients, not realizing, apparently, that he has put his finger on the secret force responsible for the superior results achieved in the private practice of medicine. His complaint has a distinct spoiled-child, or possibly dog-in-the-manger flavor.

This proponent of state medicine admits his fear of competition when he brazenly supports the proposition "to deny that it would involve two standards is absurd." In other words, the people of Britain now live, sick or well, under a double standard as far as medical care is concerned. Let us hope the U.S.A. does not follow this path.

DEATH TAKES DOCTOR BEATTY

LOSS of his experience alone dealt a severe blow to the Indiana State Medical Association when Dr. Norman M. Beatty, co-chairman of the Committee on Public Policy and Legislation for twelve years, died on December 5 at his home in Indianapolis.

But Doctor Beatty had more than experience in medical legislative matters in his service to the medical profession in Indiana. He was a leader; he had vision and rare understanding; and he translated wishful thinking into positive action that produced results. A fact not known generally, his accomplishments often represented real personal sacrifice.

In recent years Doctor Beatty's major efforts were directed toward improvement of Indiana's mental institutions and to the betterment of the care and treatment of mental patients. As president of the Indiana Council for Mental Health, which has jurisdiction over five mental hospitals, two schools for the feeble-minded and the Village for Epileptics, he recognized that the state's care of its unfortunates is its most sacred duty, but that basically it is a medical problem.

Under his guidance the LaRue D. Carter Memorial Hospital, a 250-bed psychiatric facility now under construction at the Indiana University Medical Center, was planned and made possible. Doctor Beatty knew that with the scarcity of physicians Indiana would have to teach and train its own mental hospital staffs, including technical personnel. Carter Hospital is his and the Council's answer.

The Northern Indiana State Hospital, now being built at Westville, in LaPorte County, a 2,500-bed institution and the first to be built in Indiana since the early 1900's, is a partial answer to the deplorable overcrowding of our state hospitals. Again, Doctor Beatty and the Council were responsible.

Doctor Beatty was responsible for the establishment of a temporary nursery unit at Muscatatuck State School for children under six years of age, who were not accepted previously in state institutions. Through his efforts Indiana's pay schedule for hospital attendants was raised to attract better personnel. He had much to do with the fact that the state's salaries for qualified medical men are comparable to those of other states.

It will be a long time before another physician with his perspective and initiative takes an interest in so wide a field of legislative and public affairs. The medical profession of Indiana was fortunate to have had a man of Doctor Beatty's talents. Not only has the profession lost a good physician, but a man who unselfishly devoted endless hours and energy in behalf of medical legislation.

Dr. Norman M. Beatty's service to the medical profession and the mentally unfortunate of our state will live long in memory. He has left a noble heritage.

Editorial Notes

The Bulletin of the Columbus Academy of Medicine (Ohio) carried the following interesting editorial in its October issue, which we thought worthy of reproduction:

A Few Fine Distinctions

Our innocence on matters of medical economics is traditional, and it is a field we avoid discussing whenever possible. We do have, however, a penchant for statistics, and a fondness for statistical accuracy. It is this latter which leads us to a few comments on the figures which so often serve as premises for such economic discussions.

Our first objection is to figures on the average incomes of physicians which omit (as did some recent ones published in the daily press) the interne-resident group. One receives a complete misconception as to the financial pathway of a physician if this large and important body of doctors is discounted. It is absurd to argue that they don't count in such a calculation. If the average is to include only a special segment of doctors, it might as well be thrown out completely. The published figure amounted, in effect, to the average income of those doctors who make over \$100 a month. It might as logically be the average income of those doctors who make over \$200 a month, or over \$1,000 a month. If a line is to be drawn, why set it at that particular figure? Give us the average income of everyone with an M.D. degree, interning, practicing or retired, and we will have a more accurate premise for discussion.

In the second place, we object to figures issued on cost of hospitalization being lumped completely under the heading of medical care. The hospital superintendent is running a hotel in which the guests receive medical care, and the cost of the medical care starts after the hotel costs are covered. If an individual can enter a hospital, stay 24 hours and eat three meals for \$8.50, he has actually paid less than he would for the same room and meals at a down-town hotel. Which indicates that the medical care—nursing, medications and so on—has been thrown in gratis. The total cost is more accurately referred to as the cost of hospitalization, of which a very small fraction is the cost of medical care. The distinction may seem tenuous, but it is perfectly accurate, and, before we design the moving-belt type of hospital care, let's ask the Neil House to add nurses, Nembutal, Aspirin, Mineral Oil, etc., and not raise their prices.

Finally we would protest the cost of medical education being confused with the cost of the care of the indigent patient. The cost of educating a doctor is a problem for our Universities and Medical Schools. The cost of caring for indigent patients is a community problem. Since most University Hospitals deal with indigent patients, there is often a tendency to add the cost of the Hospital to the cost of the medical school and refer to them as the cost of medical education.

To choose Cornell as an apt example, this problem could best be pointed up by asking the question: "Why should a Board of Trustees in Ithaca be economically penalized because an indigent man in Manhattan contracts pneumonia?" It is fallacious to answer: "Because they want to use that patient as teaching material." In return for teaching privileges in connection with their patients, the medical school provides free professional care—it should not also provide free board and room and medications. Let us revise this statistic, charging education against the educational institutions and care of the indigent against the community.

The debates and discussions on medical economics may now continue. We have no axe to grind. Our plea is only for care in computing the figures which provide a basis for the discussion.—A. C. B.



President's Page



GREETINGS, APPREHENSIONS, AND EMERGENCIES

JANUARY 1949

HUMBLY, and with a profound realization of responsibility, I now take up my new assignment to duty as president of the Indiana State Medical Association.

I extend New Year's greetings and best wishes to all my professional colleagues in this, the Centennial Year of our state association; the culmination of a hundred years of rugged individualism, courageous initiative, scientific study, research, and achievement, and an unselfish devotion and service dedicated to the care of the sick, the relief of suffering, and the extension of human life.

Each of you has played a valuable part in this unequaled contribution of the medical profession to the welfare of man.

Today, at the beginning of our great Centennial Year, we face the greatest crisis in the hundred years of our organization, and I am extremely apprehensive about the future of our profession.

I beg you to sit down before the facts and face the cold, relentless realities.

The election is over. The answer to our problems was not in the ballot box. "It finally dawned on the fellow who was trying to figure out where the sun went, when it went down."

Most of those who openly championed the cause of American Medicine were defeated at the polls.

America, with the best medical care in the entire civilized world, forgot all about the many years of splendid services it had received from its "family doctor." It forgot the great scientific achievements and the sacrificing service of American Medicine. It remembered only the "misdemeanors," the trivial irritations, and the minor grievances in its relations with its doctor. (The little things that could be quickly corrected by every county medical society.)

Molehills were magnified into mountains by alert politicians, socialistic reformers, and sob sisters.

Millions answered the siren call of a political panacea, followed a socialistic mirage, and voted overwhelmingly in favor of a government-controlled and compulsory health service.

Congress is now convening in Washington, as this President's Page comes off the press, and will endeavor to carry out the mandates of a misguided people.

The Indiana State Legislature is now in session and will have many bills presented pertaining to health and medical care.

The cultists of Indiana are thoroughly organized and will put on the battle of the century to lower the educational requirements for licensure of the healing arts, and if successful will flood our great state with hundreds of uneducated and unqualified practitioners to treat the sick and prey on a gullible public.

Facing these cold relentless realities, I still have hope. I again say the answer to most of our problems is back home, at the crossroads, in the villages, and in the metropolitan centers, as well. I believe that the doctors can do the job and that our county medical societies are capable of providing a program of adequate medical care in every community; a program that will satisfy the people and rapidly change adverse public opinion of the medical profession. Politicians quickly sense a changed public opinion and turn handsprings to get in line.

If we fight and win the battle at the "crossroads" here in Indiana, there is still a chance for victory in Washington.

Sincerely believing that an emergency exists, I respectfully request each county medical society solemnly to consider the adoption of the following emergency program.

1st. Study the legislative bulletins and information that are being sent to you by your state and national legislative committees. Keep in close personal contact with the local members of the Indiana State Legislature throughout the entire legislative session. See that these legislators have reliable information and discuss with them the merits and demerits of every bill.

2nd. Contact your district representatives in Congress and furnish them with information and reliable data on the fallacies of a compulsory health program.

3rd. Organize, publicize, and provide around-the-clock medical service in your community.

4th. Devote the entire programs of at least the next three monthly meetings of your county society to the study of medical economics and legislation and to the improvement of public relationship.

5th. Immediately publicly announce and promote a county-wide community enrollment in Blue Cross and Blue Shield prepaid hospital and medical care insurance. Enlist your civic groups, business, industrial, labor, farm, and church leaders in your enrollment organization.

6th. Provide active medical participation, counsel, and guidance in all local lay and professional agencies of health, and especially guard against political domination of your community health council.

7th. Encourage your members to participate actively in civic affairs and serve on the health and welfare committees of the various service clubs and organizations.

8th. There should be an active woman's auxiliary to every county medical society. The ladies can do some valuable work in the present dilemma and are excellent ambassadors of good public relationship.

I am pleased to say that many counties are doing all these things now. I am sure all will do this and more to meet the present crisis in American medicine.

Again—

"I pray that our county medical societies will realize that they are the atomic force that can destroy or immortalize American medicine.

"Indiana stands at the dawn of a new century in medicine.

"An atomic century with a horizon unlimited—If we remain free men."

Augustus P. Hauss

Medical Panorama by the ASSOCIATE EDITOR

In the November issue of *ISMA News Flashes* there was a paragraph on the establishment by the Vigo County Medical Society of an around-the-clock medical service. This matter is receiving attention elsewhere, too, as evidenced by the following excerpt from the bulletin of the Alleghany County Medical Society (Pittsburgh):

"The recent action of the ACMS to assist the public in obtaining emergency treatment is a laudable forward step that should be of great value in improving the relations of the county physicians and the general public. In line with this public service, there is an additional service just as necessary, and is of help to both the doctor and the patient.

"There are many people who desire the services of a specialist but do not know how to obtain these services. They have no family physician to turn to, so have to depend on advice from neighbors, most of whom cannot give them this information. To help these individuals, the ACMS has a list of general practitioners and specialists, in geographical areas, to whom these patients can be referred. Again, as in the emergency group, let the participating physicians be men who are willing and able to take on extra work. This will automatically restrict this list to the younger men, particularly those recently finished with their training and those recently returned from service with the armed forces.

"This is a double-barreled proposition, of aid to both the public and the physician starting his practice. The younger physician, recently returned from service with the armed forces, or recently finished with his residency, feels the need of such a plan most keenly. He is trying to build up a practice, and can readily be of service to the public, yet he has to listen to people claiming vociferously that there is a shortage of physicians, that the doctors are too busy, that they can't get immediate appointments but have to wait for weeks and months, etc.

"The trouble is not the lack of physicians; it is the distribution of work among the physicians. The doctor with a well-established practice is too busy—the ones starting out haven't enough to do. This is where the ACMS can step in to correct the troubles. By judicious advertising, newspapers and radio, it can get prompter service for the public, and aid its own younger and struggling members at the same time."

Dr. H. M. Clodfelter, president of the Columbus (Ohio) Academy of Medicine, has expressed himself on psychosomatic medicine. Many of our own G.P.'s will add a hearty "Amen!" to his remarks:

"Years ago when Aunt Louise went to her family doctor, he already knew that Uncle John was in the State Prison for fraud, that brother Tom had run away with his neighbor's wife, that little Harry was an idiot, and that poor Aunt Louise had been left at the altar when Big John Applejack had eloped with the local peroxide blond. Knowing all these things when Aunt

Louise began telling of the pain in her heart, 'Doc' did not need an electrocardiogram or a chest x-ray to ascertain whether her illness was functional or pathological.

"Living conditions have changed so much that now it takes a well-trained psychiatrist several long and expensive interviews to even find out about Big John Applejack. The cardiologist has to worry considerably about the EKG and the chest film, and if she happens to have a little too much QIII poor Aunt Louise is really in a desperate plight. . . .

"The mind and body must be correlated in most human illnesses. Scabies will respond to sulphur, irrespective of the mental gymnastics of the patient, but scabies might well produce a local social uprising if one of the local nabobs happens to 'believe' that scabies is due to filth only and not to a parasite. The breadwinner of a large family, ill with pneumonia, will receive the benefit of the modern miracle drugs, but his despondency over the empty larder may keep his pulse at a high speed.

"Such is psychosomatic life."

Of great interest to all medical men is the United Nations International Children's Emergency Fund's anti-tuberculosis vaccination program. The following is from a statement released by the Public Health Service:

"The largest mass immunization ever undertaken, the program contemplates tuberculin-testing 40 to 50 million children in Europe and offering vaccination to all found to be uninfected by the tubercle bacillus. A total of \$4,000,000 has already been allocated by the Children's Fund for the work, and the testing and vaccination of European children will begin very shortly under the joint sponsorship of UNICEF, the World Health Organization, the Danish Red Cross, and other Scandinavian Red Cross chapters. After completion of the European project, similar programs may be undertaken in Algeria, Tunisia, Morocco, and China, as well as Southeast Asia and Latin America.

"The vaccination procedure, which employs BCG (*Bacillus Calmette-Guerin*), is already widely accepted as a protective measure against tuberculosis in many European countries. The vaccine was developed in 1910 by the two French scientists whose names it bears, and was first used for the vaccination of infants in 1921.

"Dr. C. E. Palmer, commenting on the research enterprise, said, 'The program presents brilliant possibilities in terms of increasing our knowledge of tuberculosis. Indeed, the project may well serve as the basis for the most extensive epidemiological study ever undertaken for any disease. For the first time, we may find the answers to many questions about tuberculosis which have been resolved in the past only by conjecture or intuition. We shall soon have ample data to provide an almost global picture of the prevalence of tuberculous infection—so that much can be hoped for the future control of the disease throughout the world.'"



AUGUSTUS P. HAUSS, M.D.

New Albany

PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1949

AUGUSTUS P. HAUSS, M.D.

PRESIDENT

INDIANA STATE MEDICAL ASSOCIATION

1949

DR. AUGUSTUS P. HAUSS, of New Albany, succeeded to the office of President of the Indiana State Medical Association on the first of January, after having spent an exceedingly busy year in the important office of President-elect.

As the Association begins its Centennial Year and prepares to celebrate its one hundredth anniversary, its members may well pledge their unstinting support and cooperation to the incoming President. His record in the past is that of a sterling citizen interested in the everyday affairs of the community, a busy general practitioner, a willing and efficient administrator for public health activities, and a careful and conscientious servant for the affairs of the medical profession in Indiana.

Doctor Hauss is not a newcomer to centennial celebrations, having been the Vice-President of the New Albany Centennial Celebration in 1913 and the President of the Floyd County Centennial in 1919. During the past year he attended the centennial meeting of the Pennsylvania State Medical Society as an official representative of our Association.

During his term of office the state of Indiana will be organizing for civilian defense and for the

protection and care of its citizens and resources in event of disaster. The medical part of such an organization is most important. Doctor Hauss' experience as Chief of Emergency Medical Services of Floyd County Civilian Defense during World War II, for which he received the Citation of Merit, and to which he attracted national recognition, will be a valuable contribution to such a plan.

His year as our President will be filled with serious and perhaps ominous problems involving prepayment medical insurance, and the threat of socialized medicine. Doctor Hauss' yeoman service as a member of many committees of the State Association, including the Permanent Study Committee on Prepayment of Medical and Surgical Care, will be an important asset in the solution of these problems.

On behalf of the members of the Indiana State Medical Association, THE JOURNAL wishes Godspeed to Doctor Hauss as he assumes the duties of President. During 1949 Hoosier doctors will review the progress of medicine for one hundred years and rejoice in its accomplishments, and meet the complex problems of a modern age, under his experienced and competent leadership.

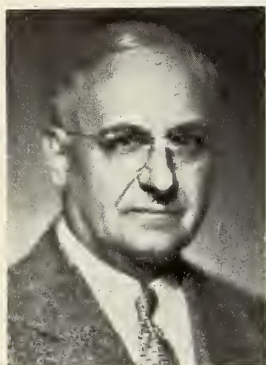


ELDRIDGE M. SHANKLIN A LEADER IN MEDICINE, AN EDITOR AND A MAN

N. K. FORSTER, M.D.*

PACIFIC PALISADES, CALIFORNIA

IT has always seemed to us to be downright indecent to talk about a living man as though he were a conscious corpse at his own funeral. However, we have always heard that it is much



better to send our choicest flowers and speak our kindest words to our living friends, than to shed our tears and echo words of praise when they are gone.

"Shank," as we know him, has been editor of our JOURNAL for the past sixteen years and, with his innate sense of dignity and inexhaustible capacity for work, has carried on the onerous and time-consuming duties of his position with distinction and justifiable pride. That he has been eminently successful in his efforts to elevate the standards of our JOURNAL, from a somewhat mediocre periodical to the front rank of state medical publications, is merely to state a fact known by all of us. His election to the office of Editor Emeritus, after so many years of fruitful effort, comes, therefore, as a mitigative factor to the feeling of regret that must be felt by all of us, as he puts aside his active pen and, reluctantly, places the cover on his typewriter. I am sure that he has earned his rest, but we are selfish enough to hope that his leisure may be tempered by a willingness to counsel and assist in those problems which will befall the one upon whose shoulders his mantle falls.

THE LEADER IN MEDICINE

Eldridge M. Shanklin has functioned in nearly every office within the gift of his medical colleagues. He was graduated from the Medical College of Indiana in 1902, and moved to Hammond to practice in 1903. He was Secretary of the Lake County Medical Society in 1909, 1912 to 1919, and 1927 to 1938. He was president of the Lake County Medical Society during the early years of its organization. In 1911-1912 he served on the State Committee on Conservation of Vision and, throughout the years, has served, often as chair-

man, on the Committees on Scientific Work, Public Policy and Legislation, Administration, Medical Defense, Arrangements, Secretaries Conference, Advisory Board to the Bureau of Publicity, and the Council on Medical Service and Public Relations. He has been Secretary of the Eye, Ear, Nose and Throat Section and Vice-Chairman of the Section on Ophthalmology and Otolaryngology. From 1918 to 1924, and again from 1929 to 1935, he was Councilor of the Tenth District and served as Chairman of the Council from 1921 to 1924. As a member and officer for many years of the Indiana State Board of Medical Registration and Examination, he conducted a one-man campaign to rid Lake County and the state of quacks and charlatans. His predecessor wrote of him: "Doctor Shanklin has done as much if not more than anyone else in efforts to uphold and enforce the medical practice acts of Indiana. He justly claims the record of closing more commercialized quackery outfits than any other living man, and in Lake County alone he closed eleven fake medical institutions in one year. In addition to closing the places and causing the owners to move from the state, he dislodged eighteen licensed medical men who were selling their medical souls for from fifteen to forty dollars per week. In all of this work he has met with considerable opposition on the part of quacks and medical pretenders, has been threatened with bodily injury, and has been taken into court and several times enjoined temporarily."

In 1925 he was elected President of the Indiana State Medical Association, an office which he filled with consummate skill and ability. Elected Alternate Delegate to the American Medical Association in 1926, and again from 1934 to 1937, he also served as Delegate from 1927 to 1929, and again in 1938.

In 1933 he was elected Editor of THE JOURNAL of the Indiana State Medical Association and has functioned in this office until the end of last year, when he was made Editor Emeritus.

We suppose that, along the line, he filled many other offices and served on many other committees, but they escape our knowledge now. Such an indefatigable worker is but another example of the verity of the phrase: "If you want something done, ask a busy man to do it." He has served in many capacities on St. Margaret Hospital Staff in Hammond, and for many years was on its Executive Board. He has found time for fraternal activities and is a past presiding officer in the

* Dr. Forster is a past president of the association, former associate editor of THE JOURNAL, and a former practitioner in Hammond. He has known Dr. Shanklin for many years.

Blue Lodge, Chapter, Council, and Commandery, of Masonry. He has never shirked activity in civic and community affairs and has always evidenced a profound interest and knowledge of political matters.

His has been a busy life and throughout it all he has maintained an active practice in ophthalmology. In addition to his county, state and American medical associations, he has been a member of the American Academy of Ophthalmology and Otolaryngology, the Chicago Ophthalmological Society, and a Fellow of the American College of Surgeons. He was one of the founders of the Indiana Academy of Ophthalmology and Otolaryngology.

Such an extensive who's who listing is not recited as proof of his medical leadership—that is too evident—but is placed on record to indicate the tremendous amount of work which Doctor Shanklin has performed during a veritable lifetime expended in the promulgation of the high ideals of our profession, and his unswerving sponsorship in the progress and advancement of medical organization.

THE EDITOR

To devote sixteen years of a man's life to the monthly publication of a medical journal, in addition to carrying on an active practice, can only result from an enormous sense of obligation and determination. It requires, in addition, limitless hours of work that must be taken from time ordinarily devoted to leisure and rest. Only those who have had the responsibility can estimate the toll demanded, a tax that is never compensated, financially or in recognition. The only reward appears to be in the contemplation of a job well done.

Shank has done his job well and most of THE JOURNAL's present-day appeal must be credited to his efforts. Gifted with a trenchant style of writing, his editorials have always depicted current events in a comprehensive manner, and he has held the interests of Indiana medicine paramount. His views have been conservative and his judgment sound. No one has a keener perception of the multiple facets of personalities in organized medicine, nor has anyone a more profound knowledge of the history of Indiana medicine during the past half century.

His interest in THE JOURNAL has been productive of many improvements. The change from drab black and white covers to the use of color and many special covers; the use of good paper stock, enhancing the appearance of the material; the general improvement in format and make-up; the institution of special numbers, devoted to particular phases of medical practice, are but a few of many changes initiated during his regime as Editor. A crowning achievement was the part he played in the reorganization of the Cooperative

Medical Advertising Bureau of the American Medical Association, and the invaluable assistance he rendered as a member of its Advisory Board.

Those who work with and for THE JOURNAL, and the membership at large, will long remember Shank as *the* Editor. He has had an inexhaustible capacity for work, a determined courage to reject undesirable articles, the ability to delete verbose contributions and uninteresting case presentations, and the talent for careful editing of articles. His active work will be missed, just as he will miss its consuming interest and demands. He will chafe a little at first because of trying to adjust himself to an altered schedule after a life of pressing activity. But the healing salve of adjustment will come in the knowledge that he has done his work—and he has done it well.

THE MAN

Born in Wildcat, Carroll County, Indiana, October 31, 1875, Shank is the son of John Calvin and Molly (Olds) Shanklin. He was educated in the country schools of Carroll County; the high school of Frankfort, Indiana; Hanover College (two years); and graduated from the Medical College of Indiana in 1902. His practice has been limited to ophthalmology, for which specialty he received training in New York, Chicago, Philadelphia and Boston. His prime interest, aside from his practice, has been writing, although he admits the recreational hobbies of fishing and gardening. He has more than a nodding acquaintance with the best literature and enjoys biographical books as a form of relaxation. He is proud of his family, his wife, three sons and a daughter, and enjoys nothing more than a gathering of the clan.

Some men are measured by the offices and honors they hold. Shank holds them both as a fitting part of his association and accomplishments during a long and valued career of participation in the work of medicine. To us, however, he is a friend of unique quality, a counselor whose clear-cut analysis has pointed the way in many a difficult situation, a chief who has directed by example and not by vested authority. His has been a measured dignity and a deep appreciation of what it means to be a doctor. His sincerity of approach to the problems of medicine has earned the lasting respect of all who cross his path. There is no show or pretense about Shank; he is blunt, to the point, unassuming and of unquestioned personal integrity. His interest in the youngster, growing up in medicine, has been a staunch quality, and his capacity for friendship, once cemented, is as sound and unfailing as Gibraltar.

Those whose privilege it is to know him hold a warm affection for him and wish him contentment and happiness in his new office. In evidence of our sincere regard we issue our certificate of work, well done—*magna cum laude*.

FRANK B. RAMSEY, M.D.

JOURNAL EDITOR

A QUIET, studious-type man . . . an inveterate reader of medical, scientific and historical literature . . . is today editor of THE JOURNAL of the Indiana State Medical Association.



He is Dr. Frank B. Ramsey of Indianapolis, a general surgeon. Doctor Ramsey has served as associate editor for a year.

Like his predecessor, Dr. E. M. Shanklin of Hammond, Doctor Ramsey enjoys gardening. After his office hours he likes to put on old clothes

and work among the vegetables and flowers. In the wintertime he chops wood for recreation . . . and for the fireplace and for exercise. He enjoys golf, but finds little time for it. Hunting and fishing do not interest him.

Doctor Ramsey is the third physician to edit THE JOURNAL, now in its forty-first year. Dr. Albert E. Bulson, Jr., of Fort Wayne, was editor and publisher for twenty-five years. He was succeeded in 1933 by Doctor Shanklin, who just completed sixteen years and is now Editor Emeritus.

The new editor held the rank of lieutenant colonel when he was discharged from the Army in March, 1946. He has continued his Army association as consultant in surgery for the Second Army Area, and three days every two months he visits Army hospitals in Indiana and Kentucky.

Doctor Ramsey has been a faithful attendant at meetings of the executive committee and council of the state association the past year and has acquired a deep understanding of the operations of the association as well as the problems of the profession. He accepted the editorship of "the best state medical journal in the country" with modesty and humility, but with a genuine liking for the work and a firm determination to carry on in the capable manner of his predecessors.

ALEXANDER W. CAVINS, M.D.

ASSOCIATE EDITOR

A NEW name appears this month on the masthead of THE JOURNAL, that of Dr. Alexander W. Cavins of Terre Haute, who became a member of THE JOURNAL's official family on January first in the capacity of associate editor.

The Council elected Doctor Cavins to succeed Dr. Frank B. Ramsey of Indianapolis, who was promoted to editor. Doctor Cavins is familiar with state medical association affairs, having served for five years (1934 - 1938) as statistician, an office no longer in existence. In 1941 and 1942 he was a member of the Study Committee on Aid to Needy Physicians.

As chairman of the Committee on Revision of the Constitution in 1946 and a member of the committee in 1948, Doctor Cavins played a heavy role in the proposed new Constitution and By-Laws to be voted upon by the House of Delegates next September.

Although born in Terre Haute, Doctor Cavins was educated in grade schools, Shortridge High School and Butler University in Indianapolis. He served in World War I, but finished his work on his A.B. at Butler in 1921.

The new associate editor received his Doctor of Medicine degree from Johns Hopkins School of Medicine in 1925 and took his hospital training at Hartford Hospital, Hartford, Connecticut, in 1925-27. In June of 1927 he began practice on the staff of the Physicians and Surgeons Clinic at Terre Haute, and since 1937 has limited his practice to work in gynecology and obstetrics at the same institution.

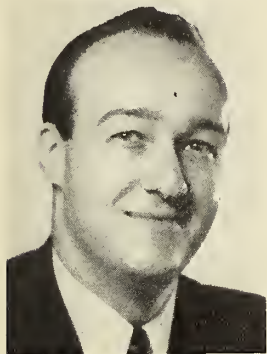
Doctor Cavins is very much interested in medical writing and will assist Doctor Ramsey in planning and editing the scientific content of THE JOURNAL.



MR. LARRY RICHARDSON

FIELD SECRETARY

THE Indiana State Medical Association has embarked upon an expanded program of activities, particularly in the fields of public relations and postgraduate education, by the addition of a field secretary to the headquarters staff.



The Council voted last April to employ a field secretary upon the recommendation of the Committee on Medical Education and Hospitals. The Executive Committee was directed to interview applicants and make a recommendation to the Council. After

consideration of many applicants, and personally interviewing nearly twenty, the Executive Committee recommended Larry Richardson, widely known Indianapolis radio newscaster, for the position, and the Council voted at a special meeting November 21 to employ him. He began his duties December 1, 1948.

Mr. Richardson comes to the association with wide experience in the radio field. His broadcasts from the window of *The Indianapolis News*, owners of Radio Station WIBC, made his personality and program known to many thousands of residents and visitors in the capitol city. In the recent campaign he directed the Radio Division of the Indiana Republican State Committee.

The new field secretary holds an A.B. and master's degree from Indiana University. Although born at Madison, Indiana, thirty-four years ago, he spent most of his life in Bloomington, Indiana. There he met and married the daughter of Dr. and

Mrs. Harry Thomas. Doctor Thomas was a practicing physician in Bloomington until his death in March, 1940.

Mr. Richardson is a member of the Methodist church, Masonic Order, Optimist Club, Cosmopolitan Club, and Sigma Delta Chi, professional journalism fraternity. He taught radio journalism at Butler University for seven semesters, and organized and administered the radio department of the Arthur Jordan Conservatory in Indianapolis for one year.

When Mr. Richardson becomes familiar with the work he will speak in behalf of Indiana medicine before lay groups, such as civic and luncheon clubs, women's organizations, Parent-Teacher associations, et cetera. It is planned for him to make yearly visits to the county medical societies, and to help them in various ways in carrying out their programs.

If and when a program of postgraduate education is developed by the Committee on Medical Education and Hospitals, Mr. Richardson will handle the details. He will be expected, too, to carry out a public relations program under direction of the Committee on Public Relations.

Mr. Richardson will devote his attention to legislative matters until March and then begin working with the Centennial Committee and Committee on Arrangements for the centennial convention, beginning September 26, 1949.

In adding the field secretary to its staff of executives, the state medical association is following the lead of most state associations, many of which have fewer members than Indiana. The second secretary will enable the association to increase its activities and do a better job for the medical profession in the Hoosier state.



All Doctors Should Hear!

"What Medicine May Expect From The 81st Congress"

An Address by

DR. JOSEPH S. LAWRENCE, Director
Washington Office of the American Medical Association

at the

Conference of County Medical Society Officers

Claypool Hotel

Indianapolis

SUNDAY, JANUARY 30, 1949

Doctor Lawrence will speak at the Luncheon at 12:30 P.M. in the Riley Room. Tickets are \$2.25 each, including waiter's gratuity. The Conference will begin at 10:30 A.M. *All doctors are welcome.* Complete Conference Program printed on opposite page.

LUNCHEON RESERVATION

Dr. A. M. Mitchell, Chairman
Conference of County Medical Society Officers
1021 Hume Mansur Building
Indianapolis 4, Indiana

Please reserve places for me at the Conference of County Medical Society Officers' luncheon at the Claypool Hotel, Indianapolis, at 12:30 P.M., Sunday, January 30, 1949.

.....M.D.

.....City

➔ Please Tear Off and Mail Before January 25, 1949
Claypool Hotel requires luncheon reservations in advance ➔

CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS ON JANUARY 30 OPEN TO ALL PHYSICIANS

A program of interest to all members of the Indiana State Medical Association has been arranged for the Conference of County Medical Society Officers at the Claypool Hotel in Indianapolis Sunday, January 30, 1949. The meeting was known in former years as the "Secretaries' Conference."

"Not only medical society officers, but all doctors are invited to attend this conference," said Dr. A. M. Mitchell of Terre Haute, chairman of the conference. "Subjects to be discussed are of vital interest to them and, in particular, will be the address of Dr. Joseph S. Lawrence of Washington, D.C., on 'What Medicine May Expect from the 81st Congress.'"

Doctor Lawrence, who is director of the American Medical Association's Washington office, will speak at a luncheon at 12:30 p.m. Luncheon tickets are \$2.25 each, including the waiter's tip. Doctors wishing to attend must make reservations. A form for this purpose is printed on the opposite page.

The conference will begin with registration at 10:30 a.m., and will adjourn shortly after 3 o'clock, so those from out of the city can get an early start home.

Time has been set aside on the program for questions and answers. Officers of the association will form a panel for an open forum, in which the audience will be invited to ask questions about phases of the state association and its activities.

PROGRAM

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| <p>10:30 a.m.—Registration, mezzanine, Claypool Hotel.</p> <p>11:00 a.m.—Call to order, Dr. A. M. MITCHELL, Terre Haute, chairman.</p> <p>11:05 a.m.—Welcome by Dr. C. S. BLACK, Warren, president-elect of Indiana State Medical Association.</p> <p>11:15 a.m.—<i>"Health and Cult Legislation in the Indiana Legislature,"</i> by Dr. J. WILLIAM WRIGHT, Indianapolis, co-chairman, Committee on Public Policy and Legislation.</p> <p>11:30 a.m.—<i>"Relationship of the County Medical Society and the County Health Council,"</i> by Dr. JOSEPH H. CLEVENGER, Muncie.</p> <p>11:50 a.m.—<i>"The Public Relations Program of the Indiana State Medical Association,"</i> by Dr. WEMPLE DODDS, Crawfordsville, chairman, Committee on Public Relations.</p> <p>12:10 p.m.—Question and Answer Period (The aforementioned speakers will constitute the panel.)</p> <p>12:30 p.m.—Luncheon, Riley room, Claypool Hotel. Dr. Mitchell, presiding.</p> <p>Greetings by Dr. A. P. HAUSS, New Albany, president, Indiana State Medical Association.</p> <p><i>"What Medicine May Expect From the 81st Congress,"</i> by Dr. JOSEPH S. LAWRENCE, director, Washington Office, American Medical Association. (Dr. Lawrence will be glad to answer questions at the conclusion of his address.)</p> | <p>2:00 p.m.—<i>"The Voluntary Prepayment Medical Care Insurance Program."</i></p> <p>a. <i>"The Status in Indiana,"</i> by Mr. R. S. SAYLOR, Indianapolis, executive vice-president, Mutual Medical Insurance, Inc.</p> <p>b. <i>"The Status Nationally,"</i> by Mr. GEORGE W. COOLEY, Chicago, assistant secretary, Council on Medical Service, American Medical Association.</p> <p>2:20 p.m.—Question and Answer Period.</p> <p>2:30 p.m.—<i>"Plans for the Centennial Convention,"</i> by Dr. J. NEILL GARBER, Indianapolis, chairman of Committee on Arrangements.</p> <p>2:40 p.m.—<i>"THE JOURNAL Program,"</i> by Dr. FRANK B. RAMSEY, Indianapolis, editor.</p> <p>2:45 p.m.—<i>"The Headquarters Office,"</i> by Mr. RAY E. SMITH, executive secretary.</p> <p>2:50 p.m.—<i>"Your State Medical Association."</i> Open Forum.</p> <p>Members of panel: President, President-elect, Chairman of Council, Chairman of Executive Committee, Member of Executive Committee, Editor of JOURNAL, association's attorney and Executive Secretary.</p> <p>The aforementioned officers will answer questions about the association and its activities.</p> <p>3:10 p.m.—Election of Chairman for 1949. Adjournment.</p> |
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A.M.A. LEVIES \$25 ASSESSMENT UPON MEMBERS TO RAISE FUNDS TO FIGHT COMPULSORY SICKNESS INSURANCE

F. S. CROCKETT, M.D.*

LAFAYETTE

FINANCED through a \$25 assessment upon each of its 140,000 members, the American Medical Association has launched a nation-wide campaign to educate the people about the evils of compulsory sickness insurance which President Truman, Federal Security Administrator Ewing and others will attempt to push through the 81st Congress. The assessments are to be collected by the county medical societies, forwarded to the state associations, and then on to the A.M.A.

The levying of the assessment, an unprecedented action, was voted by the A.M.A. House of Delegates at the interim session in St. Louis. The vote was unanimous, and was preceded by a lengthy discussion of what American medicine should do to combat the propaganda of the proponents of socialized medicine. Not one delegate opposed the assessment, but the discussion centered on the question of whether the funds should be raised by assessment or by dues. The assessment is for 1949, and whether it will be enforced in 1950 will be determined later.

The fund will be used to expand the A.M.A.'s public relations activities, and to support voluntary sickness insurance plans. Dr. George F. Lull, secretary of the A.M.A., said the money would be spent to educate the public on the progress of American medicine and the importance of conservation of health, and on the advantages of the present system of private medical care over the proposed Washington-controlled compulsory program.

NATIONAL INSURANCE COMPANY

The delegates voted against a national insurance company for voluntary prepaid medical and hospital care as proposed by the Blue Cross-Blue Shield Commissions. As a substitute, the House approved formation of a "national enrollment agency" which would coordinate all existing approved medical and hospital care plans and also help sell and distribute their services. In its action the House followed the recommendation of the reference committee and that of the Council on Medical Service.

RESOLUTION AGAINST REBATES

In a resolution adopted by the House, state medical societies were urged to consider introduction of legislation making rebates illegal in states not now having such laws. State societies were urged to "receive complaints of rebates" and hold

hearings and make investigations at their own expense in order to eliminate the practice.

Other actions of the delegates:

1. Opposed use of federal money for subsidy of medical colleges except as a last resort, and only after all sources of private supply of funds had been exhausted.

2. Approved formation of local health units and commended the United States Public Health Service for its efforts in this direction.

3. Opposed special draft of physicians by the military services. Proposed change of military organization so that doctors can be kept in medical service instead of administrative duties.

4. Criticized the practice of treating veterans with nonservice-connected afflictions in veterans hospitals unless they are indigent, and opposed the building of 150,000 more hospital beds by the Veterans Administration, the funds thus saved to be made available for hospital construction under the Hill-Burton Act, so veterans can be treated near home by the physician of their choice. This would stop competition of VA with civilian hospitals for personnel.

5. Expressed approval of the Blood Bank program of the American Red Cross, providing none is established without consent of county medical societies.

6. Approved expansion of the Washington office of the Council on Medical Service.

IN SYMPATHY WITH RESOLUTION

A resolution introduced by the delegates from Indiana, asking that the American Medical Association use its influence to discourage compulsory attendance at medical meetings, was not approved, on the grounds that the A.M.A. had itself never established any such regulation. The Reference Committee on Miscellaneous Business did report, however, that it was in sympathy with the intent of the resolution.

Two of Indiana's four delegates received reference committee assignments; Dr. Homer G. Hamer of Indianapolis served on the Industrial Health Committee, and the writer was named to a special reference committee on emergency medical services.

Dr. R. L. Sensenich of South Bend, president of the American Medical Association, participated in a public program in which Dr. W. L. Pressly of Due West, South Carolina, was presented with the General Practitioner Award, and Rev. Alphonse M. Schwitalla, S. J., dean of the St. Louis Uni-

* Delegate to the A.M.A. House of Delegates.

versity School of Medicine, was given the association's first award to a layman for public welfare service.

NATIONAL CONFERENCE OF MEDICAL SOCIETY OFFICERS

One of the most successful meetings at St. Louis was the National Conference of County Medical Society Officers, of which Dr. A. M. Mitchell of Terre Haute is chairman, and who presided. More than 400 persons attended.

Brigadier General George E. Armstrong, deputy surgeon general of the United States Army and graduate of Indiana University School of Medicine, said the question of whether doctors would have to be drafted was "entirely up to the group of youngsters who were deferred during the recent war in order to study medicine." Earlier he had said the 3,819 additional physicians are going to have to be obtained somehow by the armed forces by next June.

A.M.A. OFFICER'S PLEA

Doctor Lull told the meeting that young physicians have a responsibility to "uphold the dignity of the medical profession and enlist."

He added that many young doctors are staying out of the armed forces on the principle: "We don't know what they're going to do, so we'll let them come and get us."

General Armstrong indicated that plans for mobilization of physicians in the event of an atomic bomb attack include arrangements for great mobility and flexibility.

"On the day when such an attack occurs, if it comes, you might be in southern Mississippi," he said. "The next week you might be in Chicago, and three months later attached to a fighter squadron in the Air Forces."

ATOMIC WAR MEDICAL PROBLEMS

Medical problems which would result from an atomic bomb attack would include the need for experts to tell doctors "where you can go, how you can go and how long you can stay," because of radioactivity, and use of blood, antibiotics and other medical supplies only for those casualties who have a chance to live, he said.

Dr. Norvin C. Kiefer, senior surgeon in the United States Public Health Service, said organization of civil defense must be started immediately because wartime experience indicated that long periods of planning and practice are necessary for an effective organization.

"As long as there is any possibility that war may occur, we must prepare a civil defense system," he said. "No one will ever know how many lives were lost needlessly at Hiroshima because of the failure of any kind of medical service to function there for three days after the atomic bomb was dropped."

Rear Admiral Joel T. Boone, executive secretary of the armed forces' Committee On Medical and Hospital Services, described progress which has

been made in unifying medical services of the armed forces. In many places hospitals of one armed service take care of patients from all three services, he reported.

PANEL ON SOCIALIZED MEDICINE

Dr. Richard L. Meiling, Columbus, Ohio, a member of the A.M.A.'s Council On National Emergency Medical Service, urged establishment of a national health department, and said the armed forces must dispense with "corps pride and ceremony," in order to save as much money as possible.

A second panel discussed socialized medicine. Dr. Louis H. Bauer, Hempstead, New York, secretary of the World Medical Association, warned the doctors against government control of medical care. He said government control takes over "points essential to the practice of medicine and the result is cheap, mechanical and superficial medical service."

Lay groups throughout the world are attempting to foster government control of medical care, he asserted. Under such plans, he said, difficulties in meeting costs result in lowering the quality, not the quantity, of medical care.

Dr. Maurice H. Friedman, Washington, a private physician who is engaged in a personal crusade against Administration-sponsored proposals for compulsory health insurance, charged that statistics in a recent report by Federal Security Administrator Oscar Ewing are misleading and in some cases have been juggled intentionally for propaganda purposes. Dr. Friedman was born in East Chicago, Indiana.

"No one interested in the welfare of this nation," Dr. Friedman stated, "would want to gloss over our deficiencies. On the other hand, there is no excuse for painting the picture darker than it actually is. And there is no justification whatsoever for promising our people miracles which cannot be passed, even by an astonishingly successful politician."

Dr. Friedman said that a great deal of the report had an old, familiar sound. It was not necessary, he maintained, for Mr. Ewing to enlist the aid of "experts" in order to beat his breast about "those '40 percent of our counties' without an adequate 'general hospital.'"

"We have been hearing about these counties for years, despite the fact that not only the U. S. Public Health Service, but Mr. Ewing's own Federal Security Administration have both acknowledged the fact that the county is a poor unit in which to measure the adequacy of health services. An inventory of health services by counties exaggerates the deficiencies—i.e., it does not furnish a true picture, but a politically useful one."

Further analyzing the report, Doctor Friedman explained that in the total of 300,000 "preventable" deaths Mr. Ewing includes 40,000 deaths from accidents as one of the penalties of our present "inadequate" system of medical care. He said that

several other illogical items are included and that no references are given and no explanation is made about how these estimates were reached.

"It is true," Dr. Friedman said, "that in 1945 there were about 170,000 deaths from communicable diseases. Mr. Ewing assures us that 120,000 of these persons need not have died. In this country, however, even with our 'inadequate' medical services, progress has been so rapid that any data are out of date by the time they are published.

"In 1947, when the total number of deaths was higher than in 1945, only 137,000 deaths were from communicable diseases—that is, a drop of 33,000 deaths per year." Dr. Friedman said that he was not presuming to take full credit for this record for the medical profession because there were many other factors affecting the drop, but he pointed out that, if medicine were now socialized, it would be easy to visualize Mr. Ewing pointing with pride to the superiority of government medicine which had "saved" 33,000 persons who would have otherwise died under private practice.

"All scholars know how very difficult it is to analyze mortality and morbidity statistics and to evaluate properly the chief causes for differences between states or between two or more groups of people," Dr. Friedman continued. "Mr. Ewing is not intimidated by such difficulties. If one state has a higher mortality than another, Mr. Ewing does not hesitate to ascribe the differences to an unequal distribution of medical services.

"Or, he blames the differential on the economic status of one group as compared with another. This is an old trick which has been performed for years by the Federal Security Administration. How many times have we heard that the 'poor have more sickness than the rich and get less care?' According to a survey by Mr. Isadore Falk, one of Mr. Ewing's chief subordinates, there is a progressive increase of illness with increasing income so that the highest income groups have 40 per cent more illness than the lowest income group."

Dr. Friedman said that Mr. Falk also conducted a survey on the volume of services distributed under the present system for the Committee on the Costs of Medical Care. Both of these surveys agreed that there was no correlation whatsoever between family income and hospital services.

"Despite these data," Dr. Friedman said, "We cannot dismiss altogether the economic factor when discussing medical care. But the facts do not justify the emphasis placed on the economic factor by Mr. Ewing and his associates.

"No one can doubt that our people should be given a chance to spread the risk of illness through some satisfactory kind of insurance. But given this chance to spread the risk, there is also no doubt that our people can afford to pay for their own medical care.

"Whether medical care is supplied as it is now by private enterprise or is furnished by some governmental agency, our people are going to pay for it. They will get nothing free, despite the bait now dangled before them.

"The temptation is great to embrace any scheme which seems to offer security. But the history of our nation is characterized by struggles in which we pitted not only our security, but our very lives against threats to the freedom of the individual.

"Are we to permit the Federal Government to take over one activity after another from private enterprise until we have no private enterprise left? Is there satisfactory evidence that the Government can do everything better, more efficiently, with greater satisfaction to the individual, and at lower cost? What is this we have just learned from the Hoover Commission, that the Government spends \$10 in paper work to buy an article costing \$10 or less?

"Before long it will probably be the privilege of our people and their representatives to choose between keeping, and improving, our present medical services, or scrapping our present system in favor of a health service completely in the hands of a few men in Washington.

"This issue will not be decided by the physicians. They are but 150,000 strong, with little political pressure in the way of votes. The issue will be decided by the lay people of this country. We have faith that, given the facts, the American people will reach a wise decision. Unfortunately they do not have the facts, and the Ewing report will not help them much."

SECRETARIES & EDITORS AND PUBLIC RELATIONS CONFERENCES

Prior to the opening of the interim session, state secretaries and editors of state medical journals held a day and a half conference. Subjects on the program were directed at work in their particular fields. On Saturday, November 27, a national conference on medical public relations was held, sponsored by the A.M.A. Representatives from 43 state medical associations and Hawaii attended. In addition, 22 county societies and 19 related national organizations were represented. These two meetings are covered elsewhere in this issue.

Attending these two meetings from Indiana were: Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Ray E. Smith, executive secretary of the Indiana State Medical Association; Larry Richardson, field secretary of the association; Joseph E. Palmer, executive secretary of the Indianapolis Medical Society; and Isabella Rowilson, editorial secretary of *THE JOURNAL*.

Approximately 6,000 persons attended the interim session. The next interim session will be held in Tampa, Florida, the dates to be announced. The regular A.M.A. meeting will be held in Atlantic City, New Jersey, June 6-10, 1949.

Indiana doctors registered at St. Louis were:

Baker, A. M., New Albany
 Bankoff, Milton L., Michigan City
 Bibler, Lester D., Indianapolis
 Blazey, Arthur G., Washington
 Boyd, C. L., Vincennes
 CaJacob, M. E., Terre Haute
 Carney, John C., Monticello
 Challman, William B., Mt. Vernon
 Cockrum, William M., Evansville
 Corcoran, Patrick J. V., Evansville
 Cox, Wayne T., LaFayette
 Crockett, Franklin S., LaFayette
 Daley, Edward H., Jr., Oldenburg
 Dalton, John Eric, Indianapolis
 Day, W. Durbin, Seymour
 Denny, Melvin H., Rushville
 Des Jean, Paul A., Indianapolis
 Dukes, Joseph E., Dugger
 Edwards, B. E., South Bend
 Ellis, George M., Connersville
 Feldman, Max, South Bend
 Ferry, Paul W., Kokomo
 Folz, Charles J., Evansville
 Greaves, Robert J., Collinsville
 Goodman, Eli, Charlestown
 Grossman, W. L., North Vernon
 Hamer, Homer G., Indianapolis
 Harkcom, H. E., St. Paul
 Harris, Paul N., Indianapolis
 Hartley, C. A., Evansville
 Haslem, John R., Terre Haute
 Henderson, A., Ridgeville
 Hilldrup, Don G., Marion
 Hochhalter, Marian, Logansport
 Huber, Carl P., Indianapolis
 Huffman, Park, South Whitley
 Irely, P. R., Plymouth
 Jones, E. S., Hammond
 Jones, F. P., Indianapolis
 Kay, Oran E., Spencer
 Klaus, Julius M., Crown Point
 Klepinger, Harry E., LaFayette

Kramer, C. H., Palestine
 Laudeman, W. A., Elwood
 Lavengood, Russell W., Marion
 Levin, Ralph T., Indianapolis
 Lewis, Robert J., Lawrence
 McCaskey, Carl H., Indianapolis
 Mendenhall, Edgar N., Fort Wayne
 Merrell, Basil M., Rockville
 Mettler, D. C., Ligonier
 Mino, Victor H., Evansville
 Mitchell, Albert M., Terre Haute
 Morr, John W., Albion
 Nafe, Cleon A., Indianapolis
 Oak, David D., La Crosse
 Oak, David D., Jr., Hanna
 Omstead, Milton H., Petersburg
 Peck, Franklin B., Indianapolis
 Pectol, Charles F., Spencer
 Petitjean, Harold G., Haubstadt
 Pomeroy, Rex K., Plymouth
 Rauschenbach, Charles W., Hammond
 Rice, Thompson R., Petersburg
 Rissing, Walter J., Fort Wayne
 Ruddell, Karl R., Indianapolis
 Ryan, William J., Columbus
 Schneider, Charles P., Evansville
 Schumaker, Robert A., Terre Haute
 Schutt, J. B., Ligonier
 Sensenich, R. L., South Bend
 Showalter, J. R., Terre Haute
 Sinning, John E., Marshalltown
 Stout, H. T., Jr., Colfax
 Stroup, Tyler J., Indianapolis
 Tennis, George T., Greencastle
 Thompson, A. A., Tyner
 Thompson, Will A., Liberty
 Vandivier, Henry R., Terre Haute
 Wiedemann, Frank E., Terre Haute
 Wise, C. L., Camden
 Wright, J. William, Indianapolis
 Zweig, Elmer S., Fort Wayne

PUBLIC RELATIONS CONFERENCE

THE first National Public Relations Conference, sponsored by the American Medical Association, was held in the Statler Hotel, in St. Louis, on November 27, 1948, prior to the interim session of the A. M. A. It was attended by 240 medical public relations leaders from all parts of the Nation, and was considered such a success as to insure its becoming an annual event. The theme of the conference was "Common Targets in Medical Public Relations."

Among other outstanding speakers on the program was Mr. Clem Whitaker, general counsel for the California Medical Association, who told how an aroused profession in that state raised money, worked and linked with other groups in a drive which defeated Governor Earl Warren's plan to blanket his state with a "little socialized medicine plan." Before the profession started to work, Mr. Whitaker said, the Governor's plan looked like a "sure fire" proposition.

Indiana's Dr. R. L. Sensenich, A. M. A. president, said that the younger physician, especially, must

be made to realize that medicine must be a service to the individual and that every doctor has to understand fully his obligation to the public. "The physician who takes no interest in public relations is badly mistaken," he declared.

Dr. Paul Hawley, Hoosier head of the Blue Cross-Blue Shield Commission, said the profession should not be lulled into the belief that President Truman will not vigorously push a bill calling for some phase of compulsory health legislation. "He is sincere in his belief that it would be the best thing for the people of the country," he explained. Doctor Hawley, among other things, called for the enrollment of 50,000,000 more people in voluntary health plans, as an answer to government compulsion.

An expanded public relations program would be tied in with the fight against state medicine. Emphasis would be made in national magazines, newspapers, radio, speeches, etc., that the principal individual to suffer under a compulsory health plan would be the patient, because of a deterioration in the quality of medical care.

CONFERENCE OF STATE MEDICAL ASSOCIATION SECRETARIES AND EDITORS

THE American Medical Association conducted the annual Conference of State Medical Association Secretaries and Editors on November 28 and 29, 1948, immediately preceding the interim session of the A.M.A.

The meeting was held in St. Louis, under the able chairmanship of Dr. Dwight L. Wilbur of San Francisco. Dr. Wilbur is the editor of *California Medicine*, and was just finishing a year's service as chairman of the Program Committee for the Conference.

SYMPOSIUM ON MEDICAL LEGISLATION

The Symposium on Medical Legislation was addressed by Dr. Edward J. McCormick of Toledo, Ohio, Trustee of the A.M.A., by Dr. Dwight H. Murray of Napa, California, and by the Honorable Forest A. Harness, of Kokomo, Indiana.

Doctor McCormick discussed medical legislation from the viewpoint of the Board of Trustees. He stressed the advantages of clearing all opinions regarding questions of a medical economic nature through a single agency, in order to avoid the rendering of contradictory opinions by two separate agencies. He also emphasized the importance of effective liaison between the state associations and the A.M.A. on all legislative matters. He described the process by which legislative policies are determined by the A.M.A., in instances where speed is essential.

Doctor Murray gave an interesting and instructive outline of the procedures open to individual physicians for the selection of the candidates for public office who are friends of the profession, and for the encouragement of our friends to become candidates. He also discussed ways and means by which doctors can aid in the election of these candidates, and the measures which should be employed to assist them after they are in office.

Mr. Harness expressed the view that doctors should be interested in and should participate in practical politics. He considers the medical profession to be suited, by education and training, for leadership, but thinks that so far as politics is concerned it has remained too much on an academic level. His recommendation for the improvement of medical public relations is three-fold. He feels that physicians should be more active in supplying information to emphasize the superiority of the American system of medicine, in supplying information to emphasize the inferiority of political medicine, and in supplying information on the quantity and quality of medical care which is being furnished at present.

ADVERTISING BUREAU

The Conference received a report on the Co-operative Medical Advertising Bureau given by Dr. Stanley B. Weld, of Hartford, chairman of the

Bureau's Advisory Committee, and by Mr. Alfred Jackson, Director of the Bureau. The Bureau is a nonprofit agency organized for the solicitation of ethical medical advertising on a national basis. Its operations during the year have been highly successful. It has supplied most of the national advertising which has been carried in the great majority of the state journals.

CONFERENCE ON MEDICAL SOCIETY RADIO PROGRAMS

The first speaker, Dr. Jonathan Forman, editor of the Ohio State Medical Journal, told his radio conference listeners that he conceived of radio primarily as entertainment, with the educational values coming second. The program series put on in Ohio under his direction stressed good health as a personal problem, while underlining to his farm listeners that their farms are all really health centers since good food comes only from good soil, well tilled.

"Our problem," said Doctor Forman, "is to make more people healthful, not get more doctors." He stated that public health services under Government control would be both expensive and wasteful, because of the long chain of bureaucrats involved.

Doctor Forman suggested that radio programs for the medical profession should feature well-known doctors, with perhaps one doctor interviewing another. He suggested also that the hygiene-lecture type of program was always good, while a round table discussion on medicine was good for attracting an audience.

The second speaker, Dr. John F. Conlin of Boston, director of public information for the Massachusetts Medical Society, told how his society used the Yankee network of 28 stations for its programs.

Doctor Conlin stated his radio shows had as their objective "the best health for the most people all of the time." One good subject on the air will give you clues for a dozen others, he explained, because listeners will write in suggestions and questions which doctors featured on the programs can answer.

Dr. Earl Whedon, associate editor of the *Rocky Mountain Medical Journal* was the moderator.

CONFERENCE ON MEDICAL-HOSPITAL PREPAYMENT PLANS

This conference was conducted as a round-table discussion with Dr. Peter Pineo Chase of Providence, as moderator. Dr. Carl S. Mundy, of Toledo, chairman of the Executive Committee of Ohio Medical Indemnity, Inc., described the manner in which the Ohio plan was organized. He discussed thoroughly the reasons for selection of the indemnity type of policy, and reported that the plan had been eminently successful.

Dr. Robert L. Novy, Detroit, president of Michigan Medical Service, gave a splendid report on the Michigan plan, as an example of the service type of policy. His talk stimulated much discussion and a large number of questions from the audience. Michigan Medical Service is the largest of all the Blue Shield Plans, with well over a million members. Doctor Novy's description as to the solution of difficulties in the past, and their plans for improved policies in the future, was very interesting.

Dr. Frank Elias, of Duluth, closed the roundtable by discussing and reporting upon the experiences of the cooperative groups in relation to their attempts to obtain medical service on the cooperative principle.

CONFERENCE ON MEDICAL LEGISLATION

Mr. Charles Crownhart, executive secretary of the Wisconsin State Medical Association, presided at this session with Dr. E. J. McCormick, Toledo, Ohio, and Dr. Dwight H. Murray, Napa, Calif., both members of the A.M.A.'s Board of Trustees, as the "board of experts."

Most of the conference time was given over to discussion of the best methods to combat the threat of state monopolies in medicine. The consensus was that the profession must: (1) Make its influence more widely felt in the Washington legislative halls, and (2) Embark on an educational campaign employing all media of publicity to convince the public that state medicine would be a bad thing for the health and welfare of the people.

One discussant from California said:

"Let's stop kidding ourselves. We have to lobby just like everyone else. We have to get in there and pitch. If we don't—."

STATE MEDICAL JOURNAL CLINIC

The medical journals of the states of Arizona, Pennsylvania, South Carolina and Texas, were the subjects for analysis and discussion, with Dr. Dwight L. Wilbur as presiding officer. Format and typography were discussed in general and as applied to each journal by Mr. John Lamoreaux, *The Warwick Press*, St. Louis. The editorial content of each was reviewed and criticized by Dr. Edwin P. Jordan of Cleveland. Mr. Harry C. Phibbs of Chicago outlined the relationships of the state journals to medical advertising and stressed the growing importance of medical periodicals in advertising.

FINAL SESSION

At the final session of the conference Dr. Paul R. Hawley spoke on Medical and Hospital Care Prepayment Plans, and presented his views on the subject of a national agency for the enrollment of prepayment insurance accounts for industries employing workers in several states.

"Medical Care of the Nation in the Event of Another War," was presented by Dr. James C. Sargent of Milwaukee, Chairman of the Council on National Emergency Medical Service. Doctor Sargent discussed the problems of allocating medical personnel in such a way as to provide the armed services with adequate medical service, without disrupting the care of the civilian population.

An interesting and informative talk on the medical aspects of atomic explosions was given by Captain R. H. Draeger, United States Navy.

The conference was closed with reports by the moderators of the conferences on Radio Programs, Prepayment Plans, and Medical Legislation.

HEALTH PROGRESS IN THE UNITED STATES

General health conditions in the United States have improved to an extraordinary extent in recent years despite depression and war, according to *Health Progress 1936 to 1945* newly published by the Metropolitan Life Insurance Company as a report upon the mortality experience among the company's millions of industrial policyholders. The report is a documented analysis of about 150 pages by Dr. Louis I. Dublin, second vice-president and statistician of the Metropolitan, and is intended for distribution in medical, public health and other professional fields.

It is a striking fact that the death rate among the insured was lower in each year of the decade under review than it was in any year of the preceding quarter century, even when the record includes deaths from enemy action in World War II, of which there were more than 29,000 among the policyholders.

Dr. Dublin states: "The favorable record during the war years is particularly noteworthy. During this period millions of workers migrated to war industry centers, lived in crowded quarters, and worked long hours at arduous tasks. Medical and public health services were curtailed, and food and fuel were often in short supply. Moreover, the concentration of troops in training camps increased the

hazard of infection, and the assignment of our armed forces to various parts of the world exposed them to tropical diseases and to other maladies not found in our own country.

"As against these unfavorable conditions were the epoch-making advances in medical science achieved in the decade. Outstanding among the newer developments was the introduction of the sulfa drugs and of penicillin, which have succeeded in saving large numbers of persons who formerly would have died from pneumonia, endocarditis, meningitis, puerperal septicemia, and other infectious diseases. The widespread use of blood plasma, blood proteins, and whole blood has reduced the number of fatalities from shock and hemorrhage. Marked progress was made also in surgery, obstetrics, and many other fields of medical practice."

In the preface to *Health Progress 1936 to 1945*, Dr. Dublin writes that the report presents "a dramatic record of the conquest of many important diseases, and substantial progress in the control of others. This is a story of achievement, and points up what still remains to be done to protect the health of the people. It is a source of satisfaction to us in the life insurance business to be able to make this contribution to the advancement of medical science and to the furtherance of the public welfare".

SELECTIVE SERVICE AS IT RELATES TO THE PHYSICIAN*

HAROLD R. HENNESSY, M.D.†

CHICAGO

THE organization which I represent, the Council on National Emergency Medical Service of the American Medical Association, appreciates the opportunity of appearing before the Indiana State Medical Association and outlining the thoughts of our members in connection with national security.

There is no argument about whether the Armed Services should have adequate medical personnel to enable them to perform their assigned mission.

From the very beginning of our history as a nation, the medical profession has had great traditions in the struggles and pains of war. Professional attainments, devoted service to the sick and wounded, and gallantry in action have always characterized the typical American doctor in the uniform of this great land.

Recent experiences confirm the fact that if America is to maintain her position of world leadership, a major effort consistent with our system of Democracy must be made to maintain an effective medical service available to all portions of our population. Today this objective presents as never before a real challenge, because if we fail we may become victims of our own scientific, economic and social development.

For what now lies ahead the task is one of providing medical service not only for the Armed Services but also for industry, agriculture and the civilian population at large.

In the light of the experience of those countries suffering the effects of serious bombing during World War II and giving heed to the threat of the atom bomb, the need of planning adequately for the medical and associated problems in the care of our entire population has become a matter of first magnitude, since the very life of our nation may hinge upon it.

When one considers the present instability of international relationships, it has become apparent that medicine is destined to play an important and far-reaching role in the national security program.

The effective number of available physicians in the United States is a valuable and relatively fixed human resource which cannot readily be increased. Therefore, the American Medical Association continues to subscribe to the concept that strict economy in the use of professional personnel should and must be continued as one of the corner-

stones in our nation's effort to secure the peace of the world.

As an aid to visualizing this picture, let us look briefly at the estimated number of physicians in general practice. (See Chart I.) These figures are based upon records compiled by Mr. Frank V. Cargill, Director of the American Medical Association Directory Department, and issued as of September 15, 1948.

The House of Delegates of the American Medical Association, in June 1948, cognizant of its responsibility to the profession and to the public, approved certain basic principles with respect to the medical, health and sanitary aspects of national defense and the expansion of the military establishment under threat of a national emergency. Time does not permit the reading of each principle. However, as number seven is especially applicable to the subject of this paper, it is quoted:

"In the event of war or the threat of war requiring medical personnel in numbers beyond those voluntarily enlisting, whatever the program of procurement of additional physicians may be, that program should in all fairness take into account the obligation that students, deferred and taught at public expense during the recent war years, have to their government and it should take into account the sacrifices already made by those physicians who served during the recent war.

"Except as age, infirmity or absolute irreplacability may forbid, the call to military duty should be in the following order of priority:

"(a) Those recent graduates who were enrolled in A.S.T.P. or V-12 programs who have not completed their obligated tours of duty as medical officers and all others who were deferred by Selective Service to continue their medical education;

"(b) other physicians who did not serve in World War II, and

"(c) those physicians who served the least in World War II."

The entire list of principles, as amended and as adopted at the 1948 Chicago Session, is carried in Appendix I. Also, this material is available through the regular facilities of the Association.

To assist in visualizing the organization for National Defense, let us look briefly at the Organization Chart. (See Chart II.) Your attention is invited to the three units which have direct access to the President of the United States. They are the National Security Council, the National Security Resources Board and the Secretary of Defense. It is appropriate to point out that the American Medical Association continues to be identified among those groups which are urging upon the President of the United States and the various agencies of the Government, including con-

* Presented at the General Meeting of the Indiana State Medical Association at the Annual Session in Indianapolis, on October 28, 1948.

† Secretary, Council on National Emergency Medical Service, American Medical Association.

gressional committees, the pressing necessity for continued development of policies, procedures and programs concerning the coordination and study of the numerous problems of a medical, health and sanitary nature involved in mobilization of our nation's manpower, resources and materials in the broadest terms and at the highest level.

To date a Medical Advisory Committee to the Chairman of the National Security Resources Board has been established. It is made up of five physicians and one dentist. They are Dr. Edward L. Bortz of Philadelphia, Dr. James C. Sargent of Milwaukee, Dr. William P. Shepard of San Francisco, Dr. A. C. Bachmeyer of Chicago, Dr. Michael E. DeBakey of Houston and Dr. Percy T. Phillips, a dentist, of New York. This recently appointed Advisory Committee, responsible to the Chairman of the National Security Resources Board, will aid the Board in developing basic policies in the field of health and medicine. They are also concerned with problems dealing with the orderly integration of the medical profession into the National Security Program. One of the prin-

cipal continuing functions of the Board, established under authority of the National Security Act of 1947, is to advise the President concerning coordination of military, industrial and civilian mobilization. Total requirements, both civilian and military, will be compared with the estimated total potential supply.

To assist in visualizing the organization of the National Security Resources Board, let us examine Chart III. (See Chart III.) The creation of this Board, as stated in the October, 1948, issue of *The Reserve Officer*, is a significant milestone in the history of the National Security Organization. It is the direct outgrowth of needs indicated by our economic mobilization experience in two wars. From the point of view of American medicine, the establishment of a Medical Advisory Committee directly responsible to the Chairman is of utmost significance.

In closing, it is desired to emphasize that America is losing her provincialism. In its place there is being created a world consciousness and a sense of world responsibility and leadership, all of which

CHART I

Corrected Copy

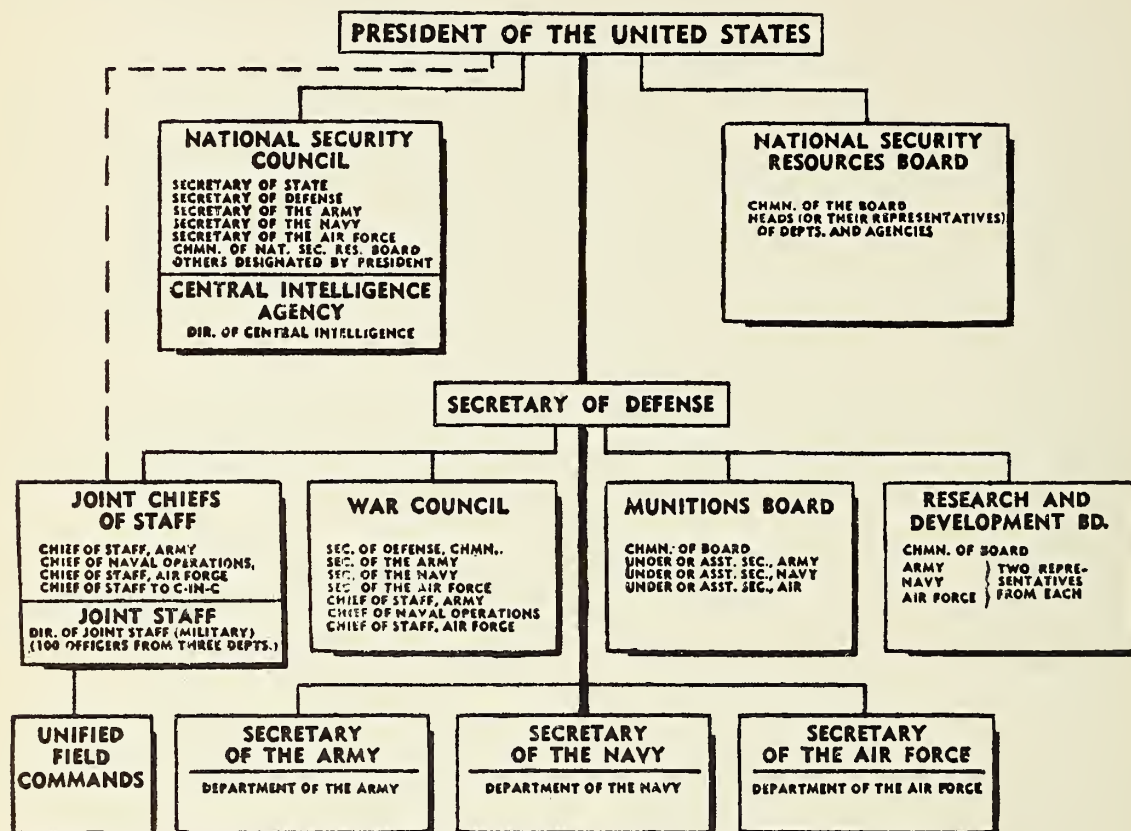
ESTIMATED NUMBER OF PHYSICIANS IN GENERAL PRACTICE

Total Number of Physicians in 1942 Directory (United States, its possessions, and Canada)	201,272
New names added	45,218
Deaths deleted	23,065
Cut from Directory for various reasons	357
Cut from Directory, Philippine Islands	4,209
Total deletions	27,631
Net Gain—Sept. 15, 1948	17,587
Total Number of Physicians in 1949 Directory as of September 15, 1948	218,859
Retired or Not in Practice	8,300
Not in Private Practice (Employed by Insurance Companies, Industrial Firms, etc.)	4,400
Full-time Hospital Service:	
Interns	7,000
Residents and Fellows	15,000
Superintendents of Hospitals (MDs.), Full-time MDs. in Tbc., Nervous and Mental Hospitals	2,688
Full-time Hospital Service—Total	24,688
Government Service:	
Regular Army	1,205
ASTP, serving with Army	2,550
ORC, and AUS, serving with Army	598
Total Army Service	4,353
Regular Navy	1,540
U.S.N.R.	1,154
Total Navy Service	2,694
United States Public Health Service	639
United States Public Health Service Reserve on Active Duty	408
Total Public Health Service	1,047
Indian Service	245
Veterans Administration (Full-time)	3,484
Government Service—Total	11,823
Total Number of Physicians Not in Private Practice	49,211
Net Estimated Number of Physicians in 1949 in Private Practice	169,648
Estimated Number of Physicians Limiting Practice to a Specialty	45,000
Estimated Number of Physicians in General Practice	124,648

From **Directory Department**,
F. V. Cargill, Director,
American Medical Association

CHART II

THE ORGANIZATION FOR NATIONAL DEFENSE



means that American medicine, as a powerful and determining force, rightfully deserves representation in all high level planning assignments. Thus, in the expanding scope of national defense which strongly suggests the size, shape and scale of things to come, we can, through joint efforts, not only assure our national security, but we may also hope to prevent World War III.

APPENDIX I

Basic Governing Principles of the American Medical Association relative to the medical, health and sanitary aspects of national defense and the expansion of the military establishment under threat of a national emergency.

(As revised and adopted by the House of Delegates, Chicago Session, June, 1948.)

1. The medical manpower of the United States is a resource vital to the life of every man, woman and child in the nation. It is a resource fixed in quantity beyond the possibility of rapid expansion. The services of physicians must be carefully conserved and judiciously allocated in time of war to insure adequate medical, health and sanitary care for all Americans, whether in or out of uniform.
2. An extremely broad and painstaking survey of the use made of medical manpower within the military establishment during World War II revealed

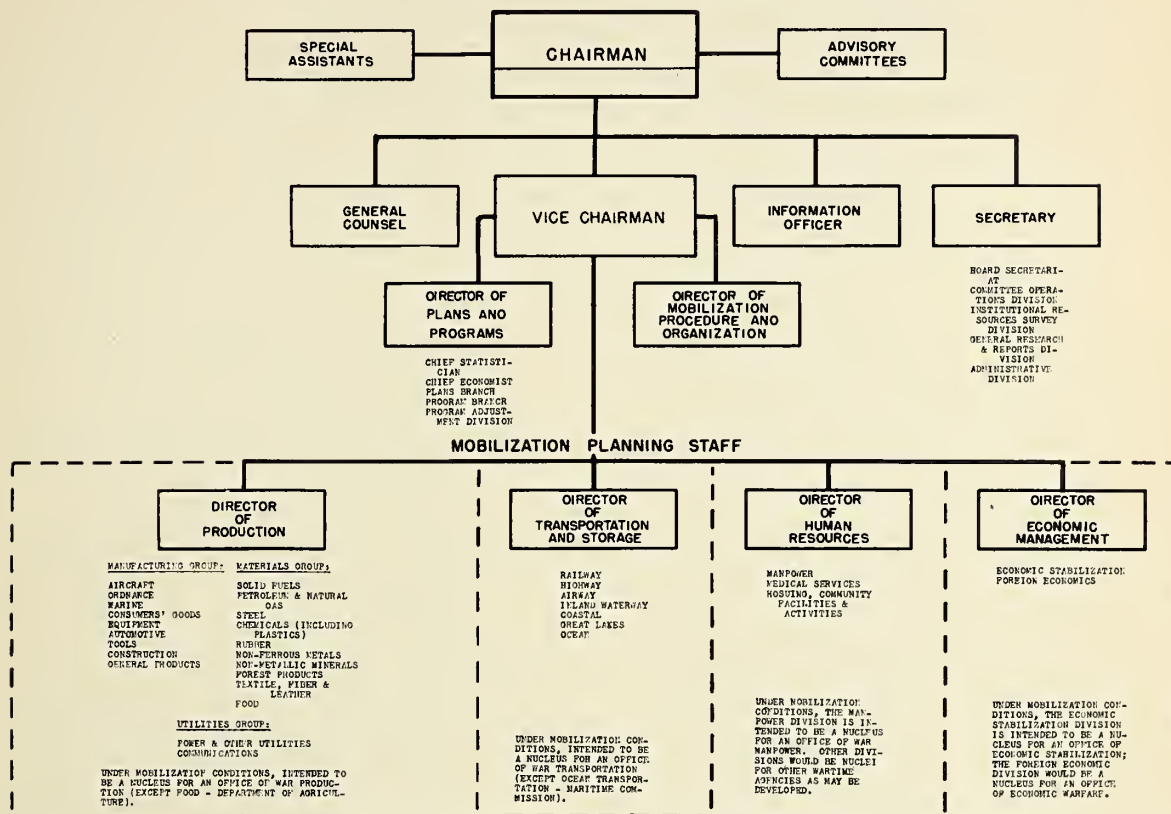
a substantial overprocurement of civilian physicians by the military establishment. Call-up to duty long in advance of need, the medical overstaffing of units, prolonged periods of complete inactivity in pooling areas and inordinate delay in separation from service are wasteful of medical talent and can be greatly minimized by improved logistics, by air and other rapid transport and by more fluid interchange of medical officer personnel between branches of the service. Protracted military indoctrination and assignments to strictly nonmedical duty should be completely eliminated.

Substantial reduction in the medical personnel requirements of the armed forces over that employed in World War II can be accomplished and medical health and sanitary care of the services actually improved by better use of the medical talents of medical officers.

3. Great wastage of medical talent is involved in duplicating the physical examination of inductees at the draft board and recruiting centers and again in reception centers. Plans should be immediately initiated which would insure procedures by which a single physical examination prior to induction into the armed forces will be carried out.
4. In the light of the experience of those countries suffering the effects of serious bombing during the last war and giving heed to the threat of the atom bomb, the need of planning adequately for the medical health and sanitary care of the

CHART III

ORGANIZATION OF THE STAFF OF THE NATIONAL SECURITY RESOURCES BOARD



civilian population becomes a matter of first magnitude since the very life of the nation may hinge on it.

It would be completely unsafe and a serious threat to our national war effort to lower needlessly the ratio of physicians to civil population anything like the 1 to 1,500 ratio reached during the recent war.

5. The making of a physician requires long, unbroken years of instruction and training. The periodic annual graduation of the usual class of new physicians could not be allowed to pass a year or two without seriously threatening the national health for a generation. Especially is this true if war is to deplete the ranks of the profession. The deferment of properly selected and duly registered premedical and medical students together with a staff of essential teachers is absolutely necessary to the future health of the nation. The same holds true for scientists engaged in important medical and allied research.
6. The present civilian medical component procurement programs of the several branches of the military establishment are highly competitive, closely confined to areas of medical teaching and research and completely unrelated to one another or to the need for deferment from military duty of the personnel they seek to enlist. There is great need for interservice coordination in the procurement of reserve medical officers and for avoiding recruitment among essential teaching and research personnel.
7. In the event of war or the threat of war requiring medical personnel in numbers beyond those

APPROVED *Arthur M. Hill*
 ARTHUR M. HILL, CHAIRMAN
 14 MAY 1948

voluntarily enlisting, whatever the program of procurement of additional physicians may be, that program should in all fairness take into account the obligation that students, deferred and taught at public expense during the recent war years, have to their government, and it should take into account the sacrifices already made by those physicians who served during the recent war. Except as age, infirmity or absolute irreplacability may forbid, the call to military duty should be in the following order of priority:

- (a) Those recent graduates who were enrolled in A. S. T. P. or V-12 programs who have not completed their obligated tours of duty as medical officers and all others who were deferred by Selective Service to continue their medical education;
- (b) Other physicians who did not serve in World War II, and
- (c) Those physicians who served the least in World War II.
8. In the event of war or threatened war, requiring the procurement by the military establishment of medical officers from civilian life, reasonable provision should be made for their replacements after tour of active duty by others from civilian life.
9. Within the limits of administrative possibilities, civilian physicians drawn into the Military Establishment should be rotated between combat and rear areas in an equitable manner.

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SCOTT	John Blunt (D) Little York	Herbert M. Copeland (R) Hanover
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Junior Senator	Hon. William E. Jenner (R) Bedford, Indiana	Sixth District	Mrs. Cecil M. Harden (R) Fifth and Liberty Sts., Covington
(Mail sent to them at Washington, D. C., should be addressed to Senate Office Building)		Seventh District	Hon. James E. Noland (D) 420 S. Fess St., Bloomington
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Second District	Hon. Charles A. Halleck (R) Rensselaer	Tenth District	Hon. Ralph Harvey (R) R. R. 4, New Castle
Third District	Hon. Thurman C. Crook (D) 311 Fulton Court, South Bend	Eleventh District	Hon. Andrew Jacobs (D) Indiana Pythian Bldg., Indpls. 4
Fourth District	Hon. Edward H. Kruse, Jr. (D) 1213 Lincoln Tower Bldg., Fort Wayne	(Mail sent to them at Washington, D. C. should be addressed to House Office Building)	

Voice of Medicine

MEDICINE ET CETERA IN HAWAII

Mrs. McCormick and I recently completed a rather extended western trip. After attending the American College of Surgeons Convention held in Los Angeles and visiting some friends on the Presidio at San Francisco, we spent two weeks in the Hawaiian Islands, happily during the time of Aloha Week.

Besides Oahu Island, on which Honolulu is located, we toured the islands of Hawaii and Kauai. The former is geologically the youngest of the eight, and is larger in area than the other seven combined. Kauai is noted for its world record of annual rain fall, 605 inches. The total population of all the islands is a little less than 500,000; 300,000 of whom live on Oahu.

During this sojourn I had the privilege of addressing the Honolulu and Lihue Medical Societies. The former has a membership of over 250—approximately 60 of whom are Japanese, and 40 Chinese. The latter society is a small group on Kauai, and many of its members are for the most part engaged in plantation practice.

The address before the Honolulu group was given in the beautiful auditorium of their Medical Society Building, a structure appraised at half a million dollars. (All hail to the day when the Indianapolis Society will have its home!)

The first thing of the medical setup to impress me was the lightedness, airiness, and freedom-from-odor atmosphere of the hospitals. Interestingly, the facilities and equipment were as adequate and modern as those of the better hospitals on the mainland. One hospital had the special feature of having a veranda connected with each room, whereby the patient's bed could be wheeled out into the open. The medical standards compared very favorably. We of the States certainly can envy them for their complete nursing staffs and surplus of empty hospital beds.

My hospital tour included that of the newly completed Tripler Army Hospital. This structure, with a total capacity of 2,000 beds and a personnel of over 1200 employees, was begun in February 1944, and completed this last August; the grounds (175 acres), buildings, equipment, and furnishings, costing in the neighborhood of \$37,000,000. There were a little over 500 patients registered in the institution.

I found the profession proud of the Territory's maternal and infant health—and quite rightly so. From June 1947 to June 1948 the maternal mortality was 1 death in 1,453 deliveries; 14,523 deliveries—10 maternal deaths. (U. S.—1 maternal death in 769 deliveries.) The infant mortality rate under 1 year (the best public health index)

for the same period was 2.9 percent (U. S.—3.3 percent). The Kapiolani Obstetrical and Gynecological Hospital (100 beds), located in Honolulu, presented the remarkable record of no maternal loss since January 1, 1948, during which time over 2,700 patients have been delivered. This record is all the more creditable in that 102 different physicians participated in these deliveries. In 1947 94.6 percent of Honolulu County mothers were delivered in hospitals, and 91.5 percent had had prenatal care. Through the medical health control program, conducted by the plantation corporations, that functions throughout the Islands, over 90 percent of all expectant mothers receive prenatal supervision and hospital delivery. (Last year in the U. S. 76.2 percent of deliveries were conducted in hospitals.)

For the Territory hemorrhage is the greatest cause of maternal mortality, and toxemia is second. This relation is the same as in the States.

No doubt many factors contribute to this health record. Among them may be listed:

1. *The climatic conditions*, which in general are more salubrious than those on the mainland—more conducive to outdoor life, fruit and vegetable diet, et cetera. However, this factor alone is not too outstanding, because some of our southern states have a near similar climate, yet experience more than twice the maternal mortality.

2. *The hybrid population*, possibly increasing hardiness. Multiple strains range from 2 to 10 in number. Five and six are not uncommon.

3. *A near 100% prenatal supervision and hospital deliveries.*

4. *The policy of compulsory consultation on the part of the general practitioners in all difficult cases.*

5. *The efficient functioning of medical health control throughout the islands.*

A likely sixth factor that exists in Honolulu County, which area represents approximately three-fourths of the Territory's population, is the teaching in the public high schools of the physiology of human reproduction, and the importance of healthy parenthood. This course has been included in their curricula for over twenty-five years. (And Indianapolis is just now beginning to consider the feasibility of this type of instruction!) Such a goal, no doubt, bears more dignity and yields more fruitfully, than that commonly taught under the caption, "Sex Hygiene."

Group medicine flourishes in Honolulu. There are two such groups of many years standing, "The

Clinic," and "The Medical Group." Each is headed by men of high reputation. The former has a staff of 23 doctors, and a total personnel of approximately 70 (nurses, pharmacutists, accountants, clerks, janitors, etc.); the latter, 16 physicians, and a similar personnel of about 45 to 50.

The incidence of puerperal sterilization, as done in three leading Honolulu hospitals, ranges from .7 percent to 4.7 percent. A critical study of the indications for the procedure has just been completed. Among the plantation population, owing to a high percent failure of ordinary contraceptive measures due to low mental status, the operation, in the minds of some physicians, is justifiable, and has been adopted in some localities to a considerable extent. Statistics show that although the birth rate has lowered, it has not reduced as rapidly as the maternal mortality rate.

There are three physicians in Honolulu who have been certified by the American Board of Obstetrics and Gynecology. There is one approved residency (1 year) in obstetrics and gynecology. Two other hospitals are expecting to have their services approved soon. The Territory has no medical school.

Tuberculosis rates sixth as the cause of death in the Islands (seventh in the U. S., being out-ranked by pneumonia). Hypertensive disease and cancer of the stomach have a high incidence among the Japanese population.

It was a glowing pleasure to find in that very liveable city of Honolulu three of my former students (H. H. Honda, '30; F. L. Giles, '34; and Ogden Pinkerton, '37) practicing happily and successfully.

There were many highlights of our trip. Our visits to the large sugar cane and pineapple plantations (as much as 18,000 acres each, and for the most part irrigated) were most interesting. However, the most outstanding was the hour's tour in a small naval craft about Pearl Harbor. The morning's beautiful, sunny calm could not dispel the painful reminiscence of that fateful event, when 3,000 Americans were killed within an hour. Of the seven major battleships that had been sunk, six have been raised. The *Arizona*, with 900 bodies within its hull, has been "ordered" to remain.

Our visit to Hawaii was made extra-enjoyable because of the lavish hospitality tendered us. From the moment of landing to that of departure, we were taken into continual tow—sometimes by physicians and their wives—sometimes by army officers—sometimes by navy officials. The former entertained and dined us in their charming mountain-side homes, which overlooked the city of Honolulu and the encircling Pacific. The grounds of each were beautifully enhanced by a great variety of tropical plants, many of which bore strange and unusual blossoms.

Alas, the parting moment ever awaits! Just before taking our leave at the airport, a group of these recent acquaintances appeared and presented us with exquisite orchids and fragrant leis, and then as we ascended the passenger steps and turned to wave "Farewell," these gallant hosts gave forth with a loud outburst of "Aloha!" "Aloha!" "Aloha!"

It was then we fully envisioned the inner Hawaiian heart, and sensed the true sweetness of parting sorrow.

C. O. McCormick, M.D.,
Indianapolis, Indiana

To the Editor,
The Journal of the Indiana State Medical Association,
Indianapolis, Indiana.

Dear Sir:

At the termination of the national emergency in 1945, we who had served in the armed forces were released under a point system. Points were given for months of service overseas and in this country, for battle stars, et cetera, and the high point men were released first.

Now we are faced with a "Draft Doctors" move. Such a thing we must try to avoid. There is yet time to make a concerted effort to offer our own solution to this problem. We must determine among ourselves who, and in what order, is to serve in the next debacle. We must decide who is to tote the barracks bags and who the money bags. The following point system is offered as a starting point for a fair and impartial means of evaluating each of us in that respect.

1. Prior Military Service:

- a. Combat service with troops—10 points per month of active service.
- b. Hospital service in various theaters—5 points per month.
- c. Service in the Zone of the Interior—3 points per month.

2. Dependents:

One dependent shall count 5 points.
Two dependents shall count 10 points.
Three dependents shall count 15 points.
(i.e. 4 dependents would total 50 points)

3. Age:

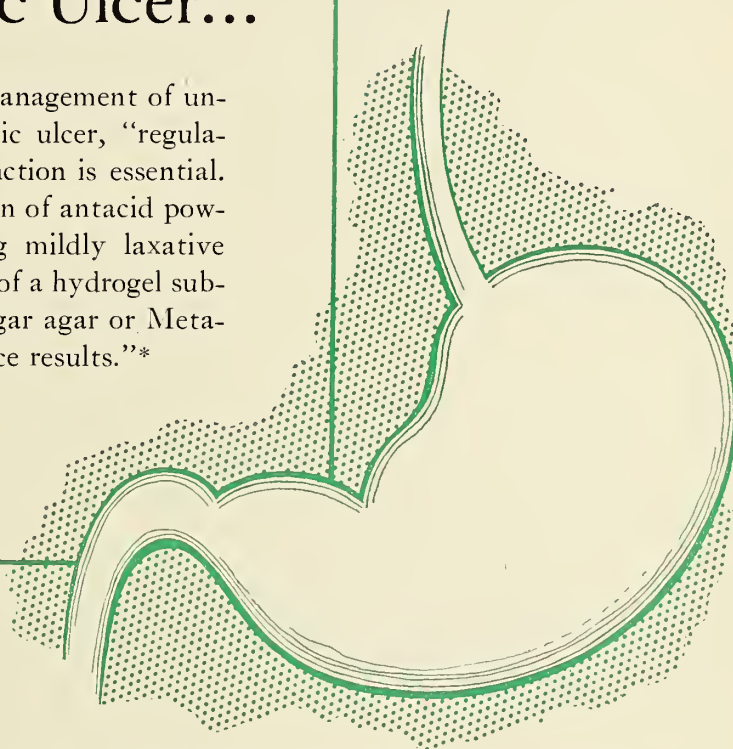
45 and over—20 points
40-45—15 points
35-40—10 points
30-35—5 points
under 30—0 points.

After all men have been scored as to points, the low point men are designated first, going progressively higher as the need arises. Specialty needs can be filled using this same system.

Byron W. Kilgore, M.D.

Bowel Regulation in Peptic Ulcer...

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Gerendasy, J.: Modern Treatment of Peptic Ulcer, J. M. Soc. New Jersey 43:84 (March) 1946.

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News Notes

Dr. George Parks, of Indianapolis, has moved to Hartford City, where he has opened an office for the practice of medicine. He is a graduate of Indiana University School of Medicine.

Dr. John F. Jackson, of Fort Wayne, is now associated with Dr. Wayne Hardin in the practice of medicine in Ossian. Doctor Jackson graduated from the Indiana University School of Medicine in 1946, and served his internship at the Lutheran Hospital in Fort Wayne. He is a veteran of World War II, having served as a lieutenant with the Army in the Pacific Theater.

A former resident of Columbus, Dr. Paul G. Donner has gone to Charlotte, North Carolina, for a residency in pediatrics at the Presbyterian Hospital there. He plans to return to Columbus to practice, following the year's residency. A 1945 graduate of Indiana University School of Medicine, Doctor Donner was with the Army Air Force at Randolph Field for fourteen months, serving in the School of Aviation Medicine there. He was in service for two years, following his internship at St. Vincent's Hospital in Indianapolis.

Dr. Bernard R. Hall has opened an office for the practice of medicine and surgery in Logansport. A 1940 graduate of the Indiana University School of Medicine, he spent his internship at Indianapolis General Hospital. Doctor Hall entered military service in August, 1941, and was discharged in October, 1945, with the rank of major. He served for twenty-two months in the Pacific Theater, and for twelve months in the European Theater. Following his separation from service, he took three years of obstetrical, gynecological and surgical training in Indianapolis General Hospital.

Dr. Stanton E. Gordon, of Connersville, was honored at a large community party which was staged in recognition of his fifty-two years of service to that community. Many of the participants in the celebration had been delivered by Doctor Gordon, and many letters and telegrams were sent to him by his "babies" from as far away as the Panama Canal Zone and from practically every state in the union.

Dr. Murray DeArmond, of Indianapolis, was elected president of the Indiana Neuropsychiatric Association recently. Other officers elected were: Dr. H. Carter Dunstone, of Fort Wayne, vice-president; and Dr. Philip B. Reed, of Indianapolis, secretary-treasurer. Members of the board of directors are: Drs. E. Rogers Smith, Earl W. Mericle, C. Basil Fausset, Louis Nie, and E. Vernon Hahn, all of Indianapolis; Dr. John H. Hare, of Evansville, and Dr. Alfred W. Snedeker, of Richmond.

Dr. Wayne Endicott, of Indianapolis, has completed arrangements to begin the general practice of medicine in Greenfield. He is a graduate of the Indiana University School of Medicine, and served his internship at St. Vincent's Hospital, in Indianapolis. After serving for two years in the United States Army Air Corps, Doctor Endicott returned to St. Vincent's Hospital, as resident physician.

Recently discharged from the Army Medical Corps, Dr. John E. Schreiner, formerly of Anderson, has opened an office for the practice of medicine in Bremen. He is a graduate of the Indiana University School of Medicine, and served his internship at St. Vincent's Hospital, in Indianapolis.

Dr. William D. Dannacher recently announced the opening of an office in Wabash for the general practice of medicine. He is a 1942 graduate of Indiana University School of Medicine, and is a veteran of three years' service in the Navy, one year of which consisted of combat surgery.

Dr. I. L. Faith, formerly of Evansville, has opened an office for the practice of medicine in Boonville. He is a 1944 graduate of the Indiana University School of Medicine, and served his internship at Indianapolis General Hospital. A veteran of World War II, Doctor Faith served as medical officer in the Navy in the South Pacific, on Okinawa. Following his discharge in 1946, he served as resident in pathology and took post-graduate work in medicine at the George Washington Medical School, in Washington, D. C. For the past year and a half he has been associated with the St. Charles Clinic in St. Charles, Missouri.

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Today, there is a wealth of clinical evidence supporting the use of Meonine as a supplement to the protein-rich diet usually prescribed for liver damage associated with malnutrition, pregnancy, allergy, certain chemical poisons, and alcoholism.

Typical of this evidence is a Beams-Endicott paper*. The authors reported that a methionine supplement seemed to cause regeneration of the liver parenchyma, in cirrhotic patients, irrespective of the amount of protein and vitamins in the diet.

Complete bibliography on request. Meonine is supplied in 0.5 gram tablets. Wyeth, Philadelphia, Pa.

*Beams, A. J., and Endicott, E. T., Histologic changes in the livers of patients with cirrhosis treated with methionine, *Gastroenterology* 9:718-735 (Dec.) 1947.



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INDIANA ACADEMY OF GENERAL PRACTICE

The first scientific session of the Indiana Academy of General Practice will be held in Indianapolis on Wednesday, February 9. All members of the Indiana State Medical Association have been invited to attend both the afternoon meeting and the dinner meeting in the evening.

The scientific program will be presented on Wednesday afternoon beginning at 1:30 P.M., in the auditorium of Indiana University School of Medicine, as follows:

"Appendicitis in the Small Hospital" (30 minutes)

Dr. Virgil McCarty, Princeton.

"Educational Requirements of Undergraduates and Graduates in General Practice" (15 minutes)

Dr. John VanNuys, Dean, Indiana

University School of Medicine.

"Tricks of Office Practice and Economics of General Practice" (One hour panel discussion)

Dr. Walter Portteus, Franklin, Moderator

Business Session for adoption of constitution and election of officers.

A dinner meeting is planned for the evening session, at the Indianapolis Athletic Club. Dr. Walter Alvarez, of the Mayo Clinic, will speak on the subject "Puzzling Functional Troubles Found in Practice."

Doctors' wives are invited to attend the dinner. The cost per plate is \$5.00, except for residents, interns, and medical students, for whom the courtesy price of \$3.50 per plate is extended.

Those who desire to attend the dinner meeting are requested to make a reservation by sending the necessary remittance to Dr. Russell J. Spivey, 2616 N. Pennsylvania Street, Indianapolis 5, prior to February 5.

The American College of Surgeons announces that six two-day Sectional Meetings will be held between January 7 and April 13, 1949, for physicians and surgeons, and professional personnel of hospitals. A seventh meeting to be held in the West the latter part of April will be announced later. The latest developments in medical science and in hospital service will be presented at each meeting. The schedule follows:

Date	City	Headquarters
January 7-8	Edgewater Park, Mississippi	Edgewater Gulf Hotel
January 14-15	Houston, Texas	Rice Hotel
February 11-12	Kansas City, Missouri	Hotel President
March 15-16	Washington, D. C.	Statler Hotel
March 21-22	Buffalo, New York	Statler Hotel
April 12-13	Edmonton, Alberta	MacDonald Hotel

Conferences for the hospital personnel and for the medical groups will run concurrently. A joint meeting of the two groups will open at 8:30 a.m. each day with the showing of medical motion pictures, followed by separate sessions at 10:00 a.m. Luncheons for the physicians and surgeons and for the hospital representatives respectively, will be held daily. Separate afternoon sessions beginning at 2:00 o'clock will be held for the two groups. There will be a dinner meeting followed by a round table conference on the first evening.

According to Dr. Dallas B. Phemister of Chicago, President of the American College of Surgeons,

several hundred persons are expected to attend each of the Sectional Meetings. Prominent local and visiting medical and hospital authorities will address the sessions.

The next written examination and review of case histories (Part I) for all candidates of the American Board of Obstetrics and Gynecology, Inc. will be held in various cities of the United States and Canada on Friday, February 4, 1949.

Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held May 8 to 14 inclusive, 1949, at the Hotel Shoreland, Chicago, Illinois. Notice of the exact time and place of the Part I and Part II examinations will be sent all candidates well in advance of the examination date.

New Bulletins are now available for distribution upon application and give details of all changes in Board requirements and regulations made at the annual meeting of the Board held in Washington, D. C., May 16 to May 22, 1948. These relate both to candidates and to hospitals conducting residency services for training.

Application forms and Bulletins are sent upon request made to American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

WHAT EVERY MEDICAL OFFICER SHOULD KNOW ABOUT THE ATOMIC BOMB

The series of articles which was reprinted in THE JOURNAL from *The Bulletin of the United States Army Medical Department* under the above title has been republished in pamphlet form and with an augmented number of illustrations. Copies of this pamphlet may be obtained by addressing the Surgeon General, Department of Medicine, Washington 25, D. C.

FEBRUARY 5 WILL BE SOCIAL HYGIENE DAY

The Indiana Social Hygiene Association and the Indianapolis Social Hygiene Association will sponsor a state-wide observance of Social Hygiene Day Saturday, February 5, in the Claypool Hotel, Indianapolis.

Dr. A. F. Weyerbacher of Indianapolis, president of the state organization, has announced that luncheon will be served in the Riley Room at noon. Tickets for the luncheon are \$1.75, including waiter's gratuity. Reservations should be made with Mrs. D. F. Buschmann, field representative, 1220 Security Trust Building, Indianapolis, telephone Lincoln 3307.

A feature of the meeting will be a symposium led by Dr. Harold Christensen of the Sociology Department of Purdue University. "Society vs. Social Hygiene and How to Meet the Challenge," will be the subject.

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Privine is generally free of systemic effect. The occasional sedative effect that may be noted in infants and young children is usually due to gross overdosage. Since there is virtually no central nervous stimulation, Privine may be applied before retiring with no resultant interference with restful sleep.



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The 77th Annual Meeting of the American Public Health Association will be held in New York City the week of October 23, 1949.

Dr. John E. Graf, of Fort Wayne, has retired from the practice of medicine, and has moved to Chicago, where his address is 4332 N. Kilbourn Avenue.

Dr. W. L. Harlan has opened an office for the practice of medicine and surgery in Cromwell. He graduated from the Indiana University School of Medicine in 1947, and spent his internship at Grace Hospital in Detroit.

Dr. O. T. Kidder, of Fort Wayne, has been appointed superintendent of the Irene Byron Sanatorium there. Doctor Kidder has been medical director and a member of the staff at the sanatorium for more than twenty years.

Dr. Raymond E. Mitchell, who was located at 3419 East Tenth Street, in Indianapolis, for the past twenty-six years, is now a lieutenant colonel at the U. S. Marine Hospital in Fort Stanton, New Mexico.

Dr. Jack H. Purcell has opened an office for the practice of medicine at Winslow. He is a graduate of Indiana University School of Medicine, and spent his internship at the Methodist Hospital in Gary, and his residency at Deaconess Hospital in Evansville.

Dr. George M. Rosenheimer, of South Bend, was elected director of district number twelve of the American Society of Anesthesiologists, Inc., during a meeting of the delegates of that organization recently in St. Louis.

Announcement has been made of the marriage, on November 6, of **Dr. Geraldine Zix**, of Indianapolis, to Mr. Arthur H. Plautz. Doctor Zix is an Indiana University School of Medicine graduate.

Dr. Edmund C. Roll is now located in full time professional capacity with the Firland Sanatorium in Seattle, Washington. A 1942 graduate of the Indiana University School of Medicine, Doctor Roll was formerly in practice at 3814 East 30th Street, in Indianapolis.

Dr. Glenn Q. Voyles, who has been practicing in Indianapolis, has moved to Twin Falls, Idaho, and has opened an office there for the practice of internal medicine.

Dr. Jack C. Blackstone, a 1942 graduate of Indiana University School of Medicine, has opened an office in Owensboro, Kentucky, for the practice of obstetrics and gynecology. He has just completed a residency at the General Hospital in Nashville, Tennessee.

Dr. Don J. Wolfram, of Indianapolis, has been appointed by President Truman as the medical representative on the Board of Appeal, Number 1, Selective Service System. This board has overall jurisdiction for Indiana in so far as appeals by registrants from local boards are concerned. The only recourse from decisions of this state group is directly to the President.

A 1942 graduate of the Indiana University School of Medicine, **Dr. Arnold J. Bachmann** has opened an office for the practice of obstetrics at 207 West 34th Street, in Indianapolis. He is a veteran of three years' service in World War II, and just recently completed a residency at the Methodist Hospital, in Indianapolis.

Dr. Daniel L. Bower has opened an office for the general practice of medicine at 3375 Forest Manor Avenue, Indianapolis. This is the office which was formerly occupied by Dr. Sidney L. Stevens, who has been appointed to a three-year ENT residency at Indianapolis General Hospital.

Dr. David Hadley has opened an office at 809 Hume Mansur Building, in Indianapolis, for the practice of orthopedics. A 1940 graduate of Indiana University School of Medicine, he is a veteran of three years and nine month's service in World War II. He was separated with the rank of major. Doctor Hadley has just completed three years of postgraduate work, including one year at Riley Hospital and two years at Indianapolis General Hospital.

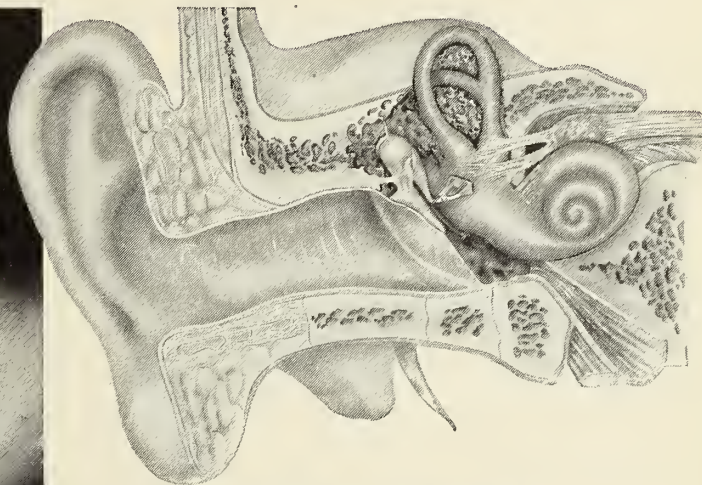
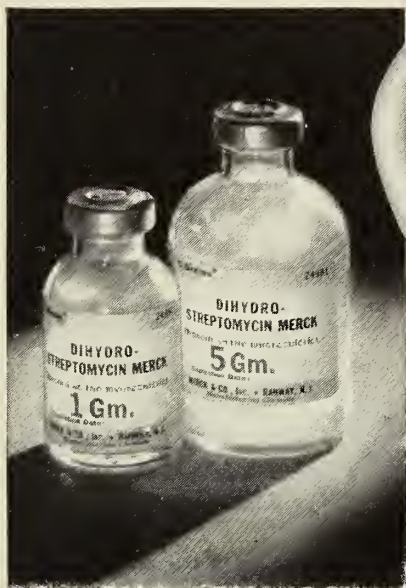
Dr. Victor J. Vollrath has opened an office at 5202 N. Illinois Street, in Indianapolis, for the general practice of medicine. He is a 1942 graduate of Indiana University School of Medicine.

Dr. Leonard C. Miller, a 1937 graduate of Indiana University School of Medicine, has opened an office at 720 Bellin Building, in Green Bay, Wisconsin, for the practice of surgery. He is a World War II veteran, with 36 month's service, and recently served a residency at the VA Hospital on Cold Springs Road, in Indianapolis.

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• Extremely Low Incidence of Vestibular Disturbances

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Dihydrostreptomycin Merck is a new, highly purified antibiotic, chemically distinct from streptomycin, and characterized by greatly reduced neurotoxicity.

Allergic manifestations due to dihydrostreptomycin therapy are rare, and no local skin irritation or other allergic phenomena have been reported thus far among personnel who frequently handle this drug.

Dihydrostreptomycin Merck and Streptomycin Calcium Chloride Complex Merck may be used interchangeably in the treatment of tuberculosis.

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ARMY TO EMPLOY CIVILIAN PHYSICIANS

General H. D. Offutt, Commander of Percy Jones General Hospital, has been authorized to employ civilian doctors for duty as general medical officers in his hospital, because of the critical shortage of Army Medical Officers. Physical requirements for the positions are very liberal, and disabled and nondisabled veterans are being given preference. The basic salary is paid to appointees who have completed an internship; a higher salary scale applies to appointees who have had at least one year's experience, in the field of medicine applied for, in addition to internship. Application may be made for full time employment, the normal tour of duty for which is 8:00 a. m. to 5 p. m., five days per week, Monday through Friday; or part time assignments may also be considered. Full particulars may be obtained by addressing the Commanding General, Percy Jones General Hospital, Battle Creek, Michigan, Attention: Civilian Personnel Branch.

MEDICAL ESSAY CONTEST

The New England Journal of Medicine has announced a prize essay contest open to all members of the class of 1949 registered in any medical school approved by the Council on Medical Education and Hospitals of the AMA.

This year's subject is: "Recent Advances in Preventive Medicine."

A cash prize of \$100 will be paid for the best essay, the paper will be published in the Journal, and the author will receive one hundred free reprints. The second prize will consist of a two-year subscription to the Journal.

Particular attention will be paid, in the judging of papers submitted, to clarity, simplicity, and general literary excellence.

AMERICAN LEGION

The American Legion, at its National Convention in Miami, Florida, October 18 to 21, 1948, adopted a resolution which originated in the Indiana Department of the Legion, and which will be of interest to the medical profession. Of the 20 four-year National Commander Scholarships which are awarded each year to orphans of veterans, five will be awarded with preference to students interested in the study of medicine and pediatrics.

The convention rejected a resolution which was introduced for the purpose of recommending that chiropractors be added to the staffs of Veterans Administration Hospitals.

A resolution was adopted to oppose any compulsory health insurance plan.

Favorable action was taken on a resolution which requested the Veterans Administration to include undergraduate training of nurses and technicians in its medical program.

The Indianapolis Obstetrical and Gynecological Society will hold its third annual dinner meeting on Wednesday, January 19, 1949, at the Indianapolis Athletic Club, at 6:30 p. m. Dr. Nicholson J. Eastman from Johns Hopkins Hospital will be the guest speaker. His topic will be "The Problem of Therapeutic Abortion As Viewed from the Past Fifteen Years' Experience At the Johns Hopkins Hospital."

This will be an open meeting and promises to be an exceptionally interesting one. Anyone interested may attend. Tickets are \$5.00 each and must be purchased on or before January 15, 1949, through the office of the Secretary, Dr. Lawson J. Clark, 420 Hume Mansur Building, Indianapolis.

SECOND MIDWESTERN CONFERENCE OF NURSING HOMES

The Indiana Association of Licensed Nursing Homes has been very active since its organization, January 15, 1945. In January of last year the group sponsored an Informal Midwestern Conference. Eleven states, including Illinois, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma and Wisconsin, were asked to participate in a program with direct bearing on raising the standards of nursing homes and offering better all-around services for the care of the aged and chronically ill. There was also the thought of organizing, on a sectional or even a national basis.

Most of the invited states sent representatives of nursing homes and staff members of State Departments of Public Welfare and State Boards of Health. Indiana was well represented. The conference was so successful and worth-while that the states of Ohio, Michigan, Minnesota and Nebraska organized on a state basis. A few states have not indicated their plans but it is understood Missouri and Kansas are planning state groups. The groups are now very active and there is fine cooperation between them.

Because of the outcome of the January meeting, the Indiana Association of Licensed Nursing Homes is sponsoring a second Informal Midwestern Conference to be held in the Claypool Hotel, Indianapolis, on January 12-13, 1949. All State Departments of Health and Welfare have been invited to attend and invitations are being sent to many operators of nursing homes and to local public and private organizations.

Dr. Walter L. Portteus of Franklin will speak on "What the Physician Should Expect from a Nursing Home," on Wednesday, January 12.

Physicians will be very welcome. It is realized they are busy persons and probably cannot attend all sessions. A program is being prepared which will be not only specific but also of broad interest.

There will be an informal dinner at 6 o'clock, Wednesday evening, in the Florentine Room, at the Claypool Hotel, and the closing session will be a luncheon, Thursday, at 12:30, in the Riley Room of the same hotel.

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properties of cigarette smoke*

Sometimes physicians may advise "Don't smoke at all." But even where that is indicated, how many patients will forego the pleasure of smoking?

For such patients, as for *all* smokers, the choice should be the least irritating of cigarettes. Many throat specialists suggest Philip Morris* because they are convinced from published studies**, as well as *their own observations* that Philip Morris alone, of all the leading cigarettes, is by far the least irritating to the sensitive tissues of the nose and throat.

Perhaps you too will find it advisable to suggest to your patients who smoke . . . "Change to Philip Morris."



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****Reprints on Request:**

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154;
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc.
Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ.
Med., Vol. 35, 6-1-25, No. 11, 590-592.

Deaths

Norman Madrid Beatty, M.D., of Indianapolis, died at his home on December 5. Although he had been in ill health since 1944, he had not been seriously ill until the last two weeks. He was recognized as Indiana's leading crusader for the care of the mentally ill. He was forty-six years of age. Doctor Beatty graduated from the Indiana University School of Medicine in 1927, and had specialized in dermatology, but his activities were not confined to the practice of medicine. During World War II his efforts in the prevention of venereal disease control resulted in the establishment of the Indianapolis Public Health Center. He served as chairman and co-chairman of the Committee on Public Policy and Legislation of the Indiana State Medical Association from 1937 through 1948. He had also served on the Committee on Arrangements, the Committee on Inter-Allied Professional Conference, Committee on Inter-Professional Health Council, Committee on Medical Service and Public Relations, and on the Scholarship Committee. He had been an alternate delegate to the A.M.A. continuously since 1938. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



* * *

Rollin H. Bunch, M.D., of Muncie, died suddenly on December 9, at the age of sixty-seven. Doctor Bunch had been mayor of Muncie three times. He was a graduate of Chicago College of Medicine and Surgery, in 1904, and was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Albert Fisher, M.D., of North Judson, died on December 2. He was seventy years of age. A graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1904, he had practiced in the vicinity of North Judson for fifty years. He was a member of the Starke County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Perry E. Cotton, M.D., of Elwood, was killed in an automobile accident on November 29. He was forty years of age. A graduate of the Indiana University School of Medicine in 1934, Doctor Cotton had practiced in Elwood for the past twelve years. He was a member of the Madison County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Harry George Erwin, M.D., of La Grange, died on November 25, after a long illness. He was sixty-five years of age. He was a graduate of the University of Illinois College of Medicine, of Chicago, in 1909, and had practiced in Edgerton, Huntertown and Fort Wayne, prior to establishing a practice in La Grange, in 1930. He was a veteran of World War I, and was a member of the La Grange County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Joseph J. Wach, M.D., of Hammond, died suddenly on November 17, at the age of thirty-four. He graduated from the Loyola University School of Medicine, in Chicago, in 1944, and was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Aljah Wright Lloyd, M.D., retired physician of Hammond, died on November 19. He was seventy-eight years of age. He was a graduate of the Hospital College of Medicine, in Louisville, in 1900, and had specialized in ophthalmology and otolaryngology.

* * *

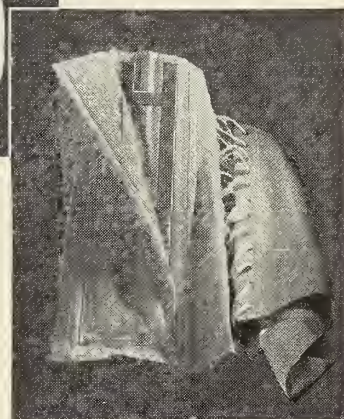
George B. Beresford, M.D., retired physician of Owensville, died on November 7, following a long illness. He was eighty-five years of age. He graduated from the Indiana Eclectic Medical College, in Indianapolis, in 1887. He entered practice at Hume, Illinois, but moved to Owensville in 1891, and had practiced there for fifty-six years until he retired in August 1947. He was an honorary member of the Gibson County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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**Hugh T. Jones, M.D.*

Low Back Pain from the Orthopedic Standpoint

California Medicine

Vol. 68, February, 1948

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

House of Delegates

**Special Meeting, World War Memorial Building,
Indianapolis, November 21, 1948**

A special meeting of the House of Delegates was held in the West Room, World War Memorial Building, Indianapolis, on November 21, 1948. The meeting was called to order at 1:20 p.m., with the president, Dr. Cleon A. Nafe, of Indianapolis, presiding.

The Committee on Credentials reported the following qualified delegates present:

<i>County</i>	<i>Delegates</i>
Adams-----	James Burk, Decatur
Allen-----	Arnold Duemling, Fort Wayne M. B. Catlett, Fort Wayne Maurice Glock, Fort Wayne
Bartholomew- Brown-----	Joseph Dudding, Hope
Boone-----	Robert H. Wiseheart, Lebanon
Cass-----	E. B. Jewell, Logansport
Clark-----	J. T. Carney, Jeffersonville
Clay-----	J. Frank Maurer, Brazil
Clinton-----	Frank A. Beardsley, Frankfort
Daviess-Martin-----	C. Philip Fox, Washington
Decatur-----	Charles Overpeck, Greensburg D. D. Dickson, Greensburg, alternate
Delaware-----	Gerald S. Young, Muncie Orville A. Hall, Muncie
Blackford-----	Paul Burns, Montpelier
Elkhart-----	A. C. Yoder, Goshen
Fayette-Franklin-----	Francis Mountain, Connersville
Floyd-----	John Paris, New Albany
Fountain-Warren-----	C. A. Nelson, West Lebanon
Fulton-----	E. V. Herendeen, Rochester
Gibson-----	Virgil McCarty, Princeton John K. Folck, Princeton, alternate
Hamilton-----	John S. Hash, Noblesville
Hancock-----	Robert O. Scott, Charlottesville
Harrison-----	William E. Amy, Corydon
Hendricks-----	O. T. Scamahorn, Pittsboro
Henry-----	Walter M. Stout, New Castle
Howard-----	Elton R. Clarke, Kokomo
Huntington-----	G. M. Nie, Huntington
Jasper-Newton-----	Frank Sink, Remington
Jay-----	George V. Cring, Portland
Knox-----	V. C. McMahan, Vincennes
Lake-----	H. W. Eggers, Hammond Ray Elledge, Hammond E. L. Schaible, Gary Harry R. Stimson, Gary
Lawrence-----	Claude Dollens, Oolitic
Madison-----	C. V. Rozelle, Anderson G. B. Wilder, Anderson S. W. Ellis, Anderson, alternate

<i>County</i>	<i>Delegates</i>
Marion-----	Albert M. DeArmond, Indianapolis James W. Denny, Indianapolis Paul G. Iske, Indianapolis Harry E. Kitterman, Indianapolis Norman S. Loomis, Indianapolis Dudley A. Pfaff, Indianapolis Frank B. Ramsey, Indianapolis O. W. Sicks, Indianapolis Dan E. Talbott, Indianapolis John M. Whitehead, Indianapolis William N. Wishard, Jr., Indianapolis J. William Wright, Indianapolis
Marshall-----	A. A. Thompson, Tyner
Miami-----	H. E. Rendel, Mexico
Montgomery-----	J. M. Kirtley, Crawfordsville
Noble-----	J. R. Nash, Albion
Orange-----	C. E. Boyd, West Baden Springs
Owen-Monroe-----	William A. Karsell, Bloomington Abraham M. Owen, Bloomington Neal E. Baxter, Bloomington, alternate
Pike-----	Milton Omstead, Petersburg
Posey-----	William B. Challman, Mt. Vernon
Pulaski-----	H. J. Halleck, Winamac
Putnam-----	Charles L. Aker, Greencastle
Randolph-----	Lowell W. Painter, Winchester
Ripley-----	William J. Warn, Milan
Rush-----	Melvin H. Denny, Rushville
St. Joseph-----	Erwin Blackburn, South Bend M. I. Hewitt, South Bend Josephine Murphy, South Bend
Scott-----	M. L. McClain, Scottsburg
Shelby-----	Roger Whitcomb, Shelbyville
Sullivan-----	Carl Briggs, Sullivan
Tippecanoe-----	R. R. Calvert, Lafayette Harry E. Klepinger, LaFayette
Vanderburgh-----	Paul Crimm, Evansville L. Paul Hart, Evansville C. C. Herzer, Evansville Philip Yunker, Evansville
Vigo-----	A. W. Cavins, Terre Haute E. O. Nay, Terre Haute
Wabash-----	G. W. Seward, North Manchester
Warrick-----	Ralph Zwickel, Newburgh
Washington-----	James P. Gilliatt, Salem
Wayne- Union-----	Harry P. Ross, Richmond William A. Thompson, Liberty
Wells-----	Truman E. Caylor, Bluffton
Whitley-----	B. F. Pence, Columbia City

Councilors

1st District—	Herman T. Combs, Evansville
3rd District—	William H. Garner, New Albany
4th District—	George A. May, Madison
5th District—	A. M. Mitchell, Terre Haute
6th District—	W. U. Kennedy, New Castle
8th District—	E. H. Clauser, Muncie
9th District—	Wemple Dodds, Crawfordsville
10th District—	William H. Howard, Hammond
11th District—	C. S. Black, Warren
12th District—	Paul A. Garber, South Whitley
13th District—	Alfred Ellison, South Bend



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 A. F. Weyerbacher, Indianapolis, treasurer
 W. L. Poriteus, Executive Committee member
 Albert Stump, Indianapolis, attorney for
 Association
 Ray E. Smith, Indianapolis, executive secretary

Delegates to A.M.A.

H. G. Hamer, Indianapolis
 William M. Cockrum, Evansville
 E. S. Jones, Hammond, alternate

Guests

L. H. Schriver, Cincinnati, president, Associated
 Medical Care Plans, Inc.
 I. C. Barclay, Evansville
 Bert Ellis, Indianapolis
 Philip T. Holland, Bloomington
 Robert S. McElroy, Princeton
 John P. Scherschel, Bedford
 Lawrence Shinabery, Fort Wayne
 Mr. R. S. Saylor, Indianapolis, executive vice-presi-
 dent, Mutual Medical Insurance, Inc.
 Mr. Guy W. Spring, Indianapolis, executive director,
 Mutual Hospital Insurance, Inc.
 Mr. Harry Davis, South Bend, executive secretary,
 St. Joseph County Medical Society
 Mr. Arthur P. Tiernan, Evansville, executive secre-
 tary, Vanderburgh County Medical Society
 Mr. John B. Twyman, Gary, executive secretary, Lake
 County Medical Society

Dr. Nafe explained that the meeting had been called to discuss the proposed formation of a national insurance company by the Blue Cross-Blue Shield Commissions, and since the matter would be voted upon by the House of Delegates of the American Medical Association at St. Louis, November 30 or December 1, so the delegates could instruct Indiana's delegates to the A.M.A. how to vote, or whether to let the Indiana delegates go uninstructed.

Dr. Nafe called upon Dr. Walter L. Portteus of Franklin, vice-president of Mutual Medical Insurance, Inc.; Dr. Roscoe L. Sensenich of South Bend, president of the American Medical Association, and Dr. L. H. Schriver of Cincinnati, Ohio, president of Associated Medical Care Plans, Inc., to discuss the question.

Others who asked permission to speak, and were recognized, were Dr. Walter L. Kennedy of New Castle, Dr. Lawrence Shinabery of Fort Wayne, Dr. Grover M. Nie, Huntington, Dr. C. V. Rozelle, Anderson, and Albert Stump of Indianapolis.

Motion was made by Dr. George Daniels of Marion, seconded by Dr. Harry P. Ross of Rich-

mond, that the Indiana delegates to the American Medical Association's House of Delegates go uninstructed. The motion carried on a voice vote.

Dr. H. J. Halleck of Winamac moved that a vote be taken of the delegates assembled so that the delegates to the A.M.A. would have an expression of sentiment upon the question. The motion was seconded by Dr. J. M. Kirtley of Crawfordsville. The vote showed 51 for approving organization of the national insurance company and 32 against such action.

A resolution calling for an amendment to the state insanity hearing law increasing physicians' fees from \$3.00 a day to \$10.00 a day and mileage from 10 cents a mile to 50 cents, as adopted by the Eleventh District Medical Society on September 15, 1948, was read by Dr. C. S. Black of Warren, councilor.

RESOLUTION

WHEREAS: The acts of the Indiana General Assembly, 1927, Chapter 69, Section 24, page 188, and amended act of 1929, Chapter 39, Section 1, page 76, set forth the fee for physicians making the statement accompanying the allegation of insanity, making out the certificate and attending the hearing, and mileage necessarily traveled in making such examination or attending such hearing.

WHEREAS: This fee is the sum of three dollars per day, and ten cents per mile, and

WHEREAS: Fees in other branches of State government have been advanced in accordance with the times, and

WHEREAS: We, of the medical profession, are usually the last to receive a reasonable fee for such services, therefore be it

Resolved, That the 11th Councilor District of Indiana go on record as being in favor of an increased fee for such services, and that this fee be a minimum of ten dollars for services rendered, and fifty cents per mile, and be it further

Resolved, that this resolution be sent to the House of Delegates to the State Convention of the Indiana State Medical Association in Indianapolis, Indiana, and that the legislative committee of the said House of Delegates be requested to act in its legislative capacity to further an amendment in the Indiana General Assembly, 1949, to rectify this condition of underpayment to physicians for these services.

WILL W. HOLMES, M.D.

O. G. BRUEAKER, M.D.

C. S. BLACK, M.D.

Motion by Dr. Grover M. Nie of Huntington, seconded by Dr. Paul Garber of South Whitley, that rules be suspended so that consideration could be given to the resolution, was passed, after which the resolution was adopted on motion of Dr. Black, seconded by Dr. Garber.

Upon invitation of Dr. Nafe, Dr. Sensenich reported on the status of Selective Service as it relates to the medical profession. This concluded the meeting.

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COMMITTEE ON PUBLICITY

November 5, 1948

Present: Homer G. Hamer, M.D., chairman; James O. Ritchey, M.D.; Cleon A. Nafe, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of December 20, 1948—"The Common Cold."

Week of December 27, 1948—"Ear Drum Damage."

The radio transcription series, "Dodging Contagious Diseases," was selected for use over WFBM, Indianapolis, beginning Saturday, November 13, 1948.

COMMITTEE ON PUBLICITY

November 19, 1948

Present: Homer G. Hamer, M.D., chairman; James O. Ritchey, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of January 3, 1949—"Broken Bones."

Week of January 10, 1949—"Stuttering."
Speakers procured:

October 15, 1948—Cass County Medical Society, Logansport. Irving Rosenbaum, Jr., M.D. "Pediatrics."

November 16, 1948—Rotary Club, Bloomington. "Scientific Medicine and Length of Life." Albert Stump.

January 7, 1949—Woman's Auxiliary to the Howard County Medical Society, Kokomo. "Local and Federal Legislation." Albert Stump.

COUNCILOR DISTRICT MEETING

THIRTEENTH DISTRICT

Dr. Dan L. Urschel of Mentone was elected president and Dr. J. E. McMeel of South Bend was elected vice-president, respectively, of the Thirteenth District Medical Society at the annual meeting held in South Bend November 10, 1948. Dr. O. E. Wilson of Elkhart was re-elected secretary-treasurer.

The next meeting will be held in South Bend on Wednesday, November 9, 1949.

The scientific program consisted of the following: "New Developments in Field of RH Factor," by Dr.

Jene R. Bennett of South Bend; "Papanicolaou Smear Diagnosis of Cancer," by Dr. Carl Culbertson of South Bend; "Peptic Ulcer," by Dr. Joseph Kirsner, Billings Hospital, Chicago; "Irregular Vaginal Bleeding," by Dr. Lester D. O'Dell, Lying-In Hospital, Chicago, and "Injuries to the Wrist: The Importance of Prompt Evaluation and Treatment," by Dr. James K. Stack, assistant professor of bone and joint surgery, Northwestern University Medical School, Chicago.

Speakers at the banquet in the evening at the LaSalle hotel were Dr. Cleon A. Nafe, of Indianapolis, president of the Indiana State Medical Association; Dr. David D. Oak of LaCrosse, selected on October 26 as the "Indiana General Practitioner of the Year" by the I.S.M.A. delegates; R. S. Saylor, of Indianapolis, executive vice-president of Mutual Medical Insurance, Inc.; Ray E. Smith, of Indianapolis, executive secretary of the state medical association; Dr. L. G. Erickson of South Bend, who gave an illustrated lecture on his trip to Europe last summer; and Dr. Alfred Ellison of South Bend, councilor, who made his report.

Dr. A. A. Thompson of Tyner, who is president of the district society, presided.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

BOONE COUNTY MEDICAL SOCIETY

President, Lloyd M. Headley, Lebanon,
Vice-President, Harvey Lovett, Whitestown,
Secretary-Treasurer, Jack Porter, Lebanon.

CLINTON COUNTY MEDICAL SOCIETY

President, H. T. Stout, Jr., Colfax,
Vice-President, George K. Hammersley, Frankfort,
Secretary-Treasurer, C. D. Holmes, Frankfort.

HENDRICKS COUNTY MEDICAL SOCIETY

President, Alan Johnston, Plainfield,
Vice-President, Harlan H. Tyner, Clayton,
Secretary-Treasurer, Ernest H. Price, Danville.

LA GRANGE COUNTY MEDICAL SOCIETY

President, H. F. Flannigan, La Grange
Vice-President, W. O. Hildebrand, Topeka,
Secretary-Treasurer, Alfred A. Wade, Howe.

OWEN-MONROE COUNTY MEDICAL SOCIETY

President, William A. Karsell, Bloomington,
Vice-President, Herman S. Hepner, Bloomington,
Secretary-Treasurer, Abraham M. Owen, Bloomington.

SWITZERLAND COUNTY MEDICAL SOCIETY

President, George Ellerbrook, Vevay,
Vice-President, George Copeland, Vevay,
Secretary-Treasurer, Robert O. Zink, Vevay.

WASHINGTON COUNTY MEDICAL SOCIETY

President, T. Kermit Tower, Campbellsburg,
Vice-President, John I. Mitchell, Salem,
Secretary-Treasurer, James P. Gilliatt, Salem.

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Adams County Medical Society members met at the Adams County Hospital, in Decatur, on November 9. The fourteen members present heard Dr. L. H. Kornafel, of Indianapolis, speak on "Recent Advances in Treatment of Goiter."

Boone County Medical Society members held a meeting at Witham Hospital, in Lebanon, on November 9. Guest speaker was Mr. Rollis Weesner, executive secretary of the Indiana State Cancer Society. Fourteen members were present.

At another meeting, on December 7, Mr. Albert Stump was the guest speaker. Twenty-four members were present.

Clinton County Medical Society members met at the Clinton County Hospital, in Frankfort, on December 7, when Dr. Clyde G. Culbertson, of Indianapolis, spoke on "Some Newer Aspects Relative to Immunity." Sixteen members were in attendance.

Greene County Medical Society members met at Freeman Greene County Hospital, in Linton, on November 11. The eight members present heard Dr. M. S. Mount, of Bloomfield, report on the state convention of the association.

Hendricks County Medical Society members met at Merritts, in Avon, on December 7. Ten members and three guests were in attendance. Election of officers for 1949 was held.

Howard County Medical Society members met in Kokomo on November 12. Dr. Michael L. Mason, of Chicago, spoke on "Treatment of Hand Injuries." Twenty-seven members and thirteen guests were present. At this meeting an advisory committee to work with the new school health physician was appointed.

Jasper-Newton County Medical Society members met at the Jasper County Hospital, in Rensselaer, on November 16. The twenty-two members present heard Dr. Cleon Nafe, of Indianapolis, speak on "The Future of Medicine."

Indianapolis (Marion County) Medical Society members met at the Athenaeum on November 2. Dr. John J. Flick, of Indianapolis, spoke on "The Management of Uveitis," and Dr. C. Basil Fausset, of Indianapolis, spoke on "Prefrontal Lobotomy."

At another meeting, on November 9, the scientific program consisted of: "Foreign Bodies in the Bladder," by Dr. John M. Young, and "Intrathoracic Tumor and Cysts," by Dr. J. V. Thompson.

At the November 16th meeting, Dr. Harold N. Cole, of Cleveland, Ohio, was the guest speaker. His subject was "The Antiquity of Syphilis with Some Observations on its Treatment Through the Ages."

Owen-Monroe County Medical Society members met at the Bloomington Country Club, in Bloomington, on November 26. The guest speaker was Dr. L. L. Shuler, of Indianapolis, who spoke on "Back Pain." Thirty members were present.

Parke-Vermillion County Medical Society members held a meeting at the Vermillion County Hospital, in Clinton, on November 17. Dr. J. L. Stoelting, of Terre Haute, spoke on "Stilbestrol in the Treatment of Threatened Abortion." Fourteen members were present.

Tippecanoe County Medical Society members met at Lincoln Lodge, in LaFayette, on November 9. Fifty-three members were present to hear Dr. John M. Dorsey, of Detroit, speak on "Psychiatry and General Practice."

Wabash County Medical Society members met at the Wabash Country Club, on November 17. Dr. G. W. Seward, of North Manchester, reported on the annual convention of the state association. Sixteen members were present.

Wells County Medical Society members met at the Caylor-Nickel Clinic, in Bluffton, on November 15. Guest speaker was Dr. Warren G. Hastings, of Fort Wayne, who spoke on "Advances in Neurological Surgery." Thirteen members were present.

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Books

THE ACUTE BACTERIAL DISEASES—Their Diagnosis and Treatment. By Harry F. Dowling, M.D., Clinical Professor of Medicine, George Washington University, and Harold L. Hirsh, M.D., Assistant Professor of Medicine, Georgetown University, 465 pages with 55 figures. Cloth. Price \$6.50. Philadelphia and London. W. B. Saunders Company, 1948.

This book has been written for physicians and medical students for the purpose of bestowing upon them the knowledge of acute bacterial diseases and their treatment. The diseases are grouped by their clinical features as well as by their etiology. It is noted that laboratory examinations and information regarding the technic of them are well presented for the purpose of getting the best results from the examinations.

For physicians desiring to keep up to date with these diseases and their treatment and for medical students, this is a very outstanding book.

BRIEF PSYCHOTHERAPY. By Bertrand S. Frohman, M.D., Beverly Hills, California, with the collaboration of Evelyn P. Frohman. 265 pages. Cloth. Price \$4.00. Lea & Febiger, Philadelphia, 1948.

This book was written by a doctor who for ten years was in general practice and fifteen years in psychotherapy; therefore, he understands the needs of physicians for this type of book, which has been written in order that they might better understand the clinical aspects of neuroses. Many short case histories are given to help the author emphasize his point, which have also aided in the diagnosing of cases. The bibliography presents an exceptional list for further reading in this field.

GENERAL ENDOCRINOLOGY. By C. Donell Turner, Ph.D., Associate Professor of Zoology, Northwestern University. 604 pages with 164 illustrations. Cloth. Price \$6.75. W. B. Saunders Company, Philadelphia and London. Copyright 1948.

"General Endocrinology" is here written as a fundamental branch of biologic science for the student in a College of Liberal Arts, not for the practicing physician. It is primarily for students preparing for medicine, dentistry, nursing, and the teaching of biologic sciences.

The integrative action of the nervous system is well understood. The subject matter of this book deals with the coordination of endocrine mechanisms in plants, invertebrates and vertebrates. Wherever possible the human being is used as the example to illustrate the biologic principles.

If a practicing physician is especially interested in a medical subject he is very likely to become again the student and be interested in the fundamental teachings. This book has brought the basic experimental information of endocrinology up to date in one volume where the interested practicing physician may find the basis for his clinical problems and what is to be expected from therapy in endocrine imbalances.

The physiology of the glands of internal secretion are considered in individual chapters and there are chapters on the gastrointestinal principles, the biology of sex and reproduction, and the hormones in pregnancy and lactation.

There are many illustrations and diagrams. There is a comprehensive bibliography at the end of each chapter and an index at the end of the book.

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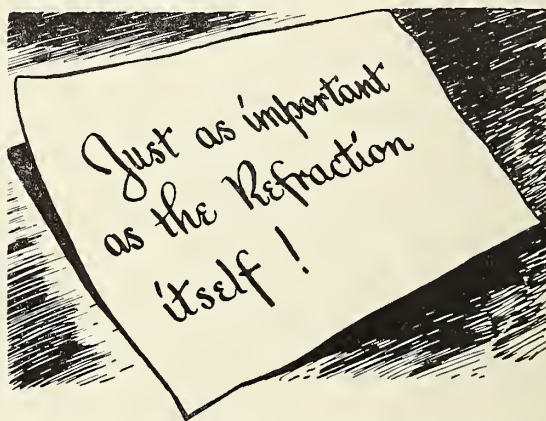
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GASTRIC AND DUODENAL ULCER*

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PHILADELPHIA

I HAVE purposely enlarged on the proposed title of this presentation. I should like to review with you some of the things that are known about gastric and duodenal ulcers. We should not collectively call these lesions peptic ulcers. It has not been proven that gastric and duodenal ulcer have a common primary etiology. It is likely that many of the so-called precipitating factors in the production of these lesions may well be of purely secondary importance.

Certain facts are known about them:

1. Gastric and duodenal ulcers, both in man and the experimental animal, tend to heal and tend to recur.
2. The duodenal ulcer is more apt to exhibit periodicity.
3. The duodenal ulcer rarely, if ever, undergoes malignant transformation.
4. Duodenal ulcer is more prone to be the site of hemorrhage or perforation than is a gastric ulcer.
5. The gastric ulcer may begin as a malignant ulcer or a benign gastric ulcer may become malignant.



There is available some evidence that nutritional deficiencies may play a role in the production of these lesions. Bile diversion in the experimental animal is an accepted method of producing such ulcerations. Almquist has shown bile acid therapy to be useful in the healing of these lesions in the experimental animal, and George S. Bergh has shown this to be true also in man. During the war years and since then the incidence of duodenal ulcer symptoms in many men recovering from infectious hepatitis and homologous serum jaundice, both of which are associated with extensive hepatocellular injury, has been high.

While the etiology of gastric and duodenal ulcer is as yet not clear, the problems of therapy have become considerably clarified during the past decade, and a sharper line can now be drawn between the indications for medical versus surgical therapy. I shall not attempt to present the medical therapy of gastric and duodenal ulcer, but anyone who has studied many patients with these lesions forms certain concepts regarding therapy in general, and these I must relate.

1. Chronic ulceration of the gastric and duodenal mucosa is very frequently associated with a neuropsychiatric background or overlay. Any form of therapy must of necessity take this fact into consideration if therapeutics is to be successful.

2. The ulceration is nearly always associated with an unusually large amount of gastric acid secretion often containing a large amount of free hydrochloric acid.

3. Pain, heartburn and other symptoms are di-

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rectly related to this abundance of free acid secretion.

4. Smoking is harmful to these patients for it increases gastric secretion.

5. The presence of food in the stomach nearly always relieves their pain.

6. The value of the Sippy diet lies in large part in the high fat content of the diet for fat retards gastric emptying time.

7. The Sippy diet, as usually administered, is low in vitamin C and may be low in the daily required protein content. Thus one, or at times the two biological factors associated with the healing of a wound—and an ulcer is a wound—may be deficient so that healing does not progress normally.

8. The tendency of gastric and duodenal ulcers to heal, during many methods of therapy, is followed after a variable time by their tendency to recur.

No one should attempt to treat these lesions without the aid of a competent radiologist, and whenever possible the same radiologist should be utilized in the progress roentgen studies of the patient. A simple water barium meal should be used for all studies, for the addition of any food-stuff to the meal will in itself alter the gastric emptying time. Thus when a simple water barium meal is used, the gastric emptying time in normal man will be about one hour and thirty-five minutes. When a small amount of chocolate is added to the meal, the emptying time may be as long as six hours. Variations such as these may well give rise to the conclusion that cicatricial stenosis is occurring at the pylorus, when in reality the condition is a purely physiological one imposed by a variation in the composition of the study meal.

The fact that what initially appeared to be a very large gastric ulcer rapidly became smaller following a few days of therapy is not always indicative of the initiation of the healing process. Contraction of the muscularis mucosa was shown by Forsell by x-ray study greatly to increase the real size of the ulcer. Such an ulcer, if one accepted Carmen's dictum, would be diagnosed as a carcinomatous ulcer. And yet a few days later, when relaxation of the muscularis mucosa had taken place, the true ulceration was relatively small. This is the base line to take for healing. One must, furthermore, make certain that apparent healing of a gastric ulcer is not due to filling in of the area of ulceration by rapidly growing malignant cells. Repeated roentgen studies will often show that what early appeared to be an ulcer defect later becomes a defect due to tumor growth.

If during medical therapy the ulcer by roentgen study shows evidences of healing as demonstrated by size, filling defect, and mobility of the gastric or duodenal wall, and the patient's symptoms have been relieved, the medical therapy should be continued.

There are in my opinion certain exceptions to this general rule as regards gastric ulcers.

1. All ulcers of the greater curvature of the stomach should be considered malignant, and should be subjected to radical gastric resection as soon as possible.

2. While ulcers proximal to the gastric incisure are frequently benign, those in the prepyloric area and on the posterior wall should always be considered malignant until proven otherwise. The prepyloric ulcers should be subjected to operation unless, on a medical program, rapid healing takes place.

Since it is often impossible, even at laparotomy, to differentiate a benign gastric from a malignant gastric ulcer, one operation is done; radical gastrectomy is not only the operation of choice, but the operation of necessity.

There are a few clearly defined indications for surgical therapy. The first and most important is acute perforation.

PERFORATION

Seely's method of using gastric suction drainage and chemotherapy in the nonsurgical therapy of perforation is not new. Rhoads and Nagel and I reported its use in 1938. Seely states that the patient should not have eaten shortly before perforation, and the patient should be seen, and therapy initiated, very early after perforation. This is a method which if widely used will lead to an increased mortality, for Seely's rigid criteria may be ignored. The duty of the physician and surgeon following the diagnosis of perforation is clear, for the most important consideration is the saving of the life of the patient. If the history is a good one and if the physical signs are positive, the surgeon need not wait for the demonstration by roentgen ray study of air under the diaphragm. Exploratory laparotomy with simple suture of the perforation and reinforcement with omentum is at present the classical therapy. Gastric resection, even in the presence of a simple chemical peritonitis, I believe, not permissible.

Gastric suction drainage should be established as soon as the perforation is closed. Under such therapy edema at the perforation site rapidly disappears and gastro-intestinal continuity is shortly re-established.

The mortality of operation after free perforation is still too high. Few surgeons can equal the late Roscoe Graham's mortality of 3 percent. Peritonitis offers the threat of major importance to life, and the longer the time from perforation to operation the higher will be the mortality with any method of therapy.

Perforation, contrary to general opinion, does not always lead to permanent healing of the ulcer. More than 50 percent of such patients continued to have serious complaints. If their symptoms continue, then subsequent therapy should be based

on the merits of the individual case. Although bilateral infradiaphragmatic vagotomy at the time of closure of the perforation might reduce the incidence of later operation, it is believed that even this procedure is inadvisable since it would increase the period of gastric retention.

HEMORRHAGE

While the indications for operation in penetrating, perforating or perforated ulcer are clear, the indications for operation in the presence of hemorrhage are not so clear; and even when operation is agreed upon, there is no unanimity regarding the type of operation which should be done.

There is no doubt but that in general a carefully controlled medical program is associated with the lowest mortality in the bleeding ulcer. In our own hospital Miller has found the mortality following the use of a Meulengracht or similar diet to be 2 percent in a series of over two hundred patients. The difficulty with many of the reported series is that they do not include the deaths which occur when, as the result of failure of a medical program, patients are transferred for operation following several days of exsanguinating hemorrhage during which time hypotension and anoxia have persisted. The surgical mortality under such circumstances is nearly 100 percent.

We must agree that the majority of patients had best be treated by nonsurgical means. The exceptions to this generalization are clearer than they were ten years ago.

1. The exsanguinating hemorrhages nearly always occur from the posterior duodenal wall ulcers. If it is known that the patient has such an ulcer, operation should be resorted to as soon as it is determined that continuing hemorrhage places the life of the patient in great jeopardy.

2. The older the patient the greater the likelihood of surgical therapy being necessary, for older patients with less elastic vascular systems stand hemorrhage more poorly.

3. A history of previous hemorrhages should be considered as an indication for operation although this may not be necessary in the emergency.

Whether the operation is done as an emergency or after cessation of the bleeding and partial recovery from the anemia, the operation for a bleeding ulcer should, in my opinion, consist of a radical gastrectomy with resection of the ulcer. Dependence must not be placed upon vagus resection. Gastro-enterostomy, with or without attempted external ligation of vessels around the site of the ulcer, is useless. In a bleeding duodenal ulcer requiring operation radical gastrectomy, without simultaneous excision of the ulcer site, is hardly justifiable. Only radical gastrectomy and duodenectomy as recommended by Roscoe Graham should be done for bleeding duodenal ulcers requiring surgical therapy. Properly planned and executed,

with blood transfusions before, during and after operation, the risk is indeed small.

Let me repeat again, the mortality of a well planned and executed medical program should not exceed 3 percent. Patients responding poorly to such a program should be operated on. If minor operations are done the mortality will be high, even if operation is done reasonably early—26 percent in our hospital. If a radical resection is done early, the mortality will be low—8 percent in our series; and if done late, when irreversible shock has supervened, it will be high—100 percent in our series. It is important, therefore, that each patient be seen frequently by both internist and surgeon and that they share the responsibility and pool their experience, judgment and therapeutic resources.

PYLORIC OBSTRUCTION

Evidence of pyloric obstruction, either from a gastric or duodenal ulcer, is not uncommon. Frequently the obstruction is not due to cicatricial stenosis but is associated with spasm or edema or both. When the obstruction is the result of pyloric spasm it is relieved, in whole or in part, by the administration of spasmolytic agents. When due to edema, with or without coincidental spasm, the differential diagnosis, even with the aid of competent roentgenologic study, may be difficult. The existence of a low plasma protein is suggestive that the obstruction is due at least in part to edema. Under such circumstances the institution of suction drainage, which puts the stomach at rest, and the administration of plasma, albumin or gelatin transfusions, will result after a few days in definite evidence of a functioning pylorus.

The chronically obstructed ulcer patient is frequently malnourished. This is often due in part to the rigid diet which medical practitioners have previously imposed on these patients; in part to a restriction in food intake by the patient because of pain; and in part to the vomiting of food ingested. Thus, many of the obstructed patients come for relief with obvious evidences of dehydration and salt loss. Within recent years this deficit has been corrected by the administration of fluid and salt by parenteral routes.

It should have been equally obvious to us that these patients may also have deficits in various vitamins, especially vitamin C and the B complex; that they may have had a serious depletion of the plasma protein; as well as a reduction of the plasma and blood volume. The preparation of these patients prior to operation is, therefore, of the greatest importance if morbidity and mortality are to be kept as low as possible.

Once the nutritional condition of the patient has been brought to as satisfactory a state as is possible, operation should be carried out. In the benign cicatricial stenoses the gastric acid concentration is frequently low and any operation

which provides an adequate stoma for gastric emptying will be associated with excellent end results. In these cases we frequently have done a posterior gastro-enterostomy; and if there remains one indication for this operation, long standing cicatricial stenosis provides it.

INTRACTABILITY TO MEDICAL THERAPY

Failure to obtain healing, the persistence of symptoms, especially pain, and the slightest suggestion of malignancy in a gastric ulcer are indications for surgical therapy. If an adequate diet has been maintained for a reasonable period, if smoking has been stopped, and mental stress and strain relieved, and if in spite of these the symptoms persist, surgical therapy is the only means worth trying. Protein hydrolysates have little to offer over a well planned and administered diet. They are no cure-all for gastric or duodenal ulcerations, and I venture to state that before long the widespread enthusiasm which greeted their early use will have passed.

I wish to warn you, however, that radical gastric resection or vagotomy should not be done merely because the patient refuses to follow or fails to live within the careful requirements of a well constituted medical program.

THE OPERATIVE THERAPY

When operation becomes necessary for a gastric ulcer, the only operation which should be done is a radical gastric resection. Local excision, pyloric resection or even vagotomy have no place in the therapy of a lesion which, if not already malignant, may provide fertile soil for subsequent neoplastic change. Vagotomy, while providing symptomatic relief, fails to remove the ulceration. All too frequently the gastroscopist and even the surgeon with the lesion in his hand cannot be sure whether the ulcer is benign or malignant. Only the microscopist can do this after study of the entire ulcer. If this be true, and I am sure that it is, a radical resection remains the operation of choice. The experience of more than a decade is sufficient to assure us that this operation is attended by a high incidence of cure, by a low incidence of recurrence of ulceration, either in the stomach or jejunum (4 percent), and by a low mortality.

In duodenal ulcer a similar type of gastric resection plus duodenectomy including the ulcer site is, in my opinion, still the operation of choice. At times the duodenal ulcer cannot safely be resected, but such instances are uncommon. When this does occur, radical gastrectomy can still be done.

Restoration of gastro-intestinal continuity by a short loop antecolic anastomosis is, I believe, the method of choice. The long loop anastomosis is in my experience the cause of much trouble subsequent to operation.

You will wonder why I have not said more regarding vagotomy. This operation, revived and

elaborated so beautifully by Doctor Dragstedt, provides a physiological approach to certain of the factors associated perhaps with the initiation of the ulcer and certainly with its chronicity. Bilateral vagotomy reduces gastric secretion and the hydrochloric acid content of this secretion. It relieves pain and provides a chemical condition more conducive to healing. It is, however, associated with a high incidence of postoperative gastric retention which occasionally becomes alarming, and in at least 75 percent of our patients has been, to say the least, most annoying.

We have performed vagotomy in approximately 50 patients. We can summarize our results with this procedure as follows:

1. A "complete" vagotomy, as judged by a carefully done insulin test, in patients with duodenal ulcer, is followed by gastric retention. The retention may give rise to troublesome symptoms for from two to twelve months. It can be corrected or prevented by another operation, gastro-enterostomy, or pharmacologically by the use of such drugs as urecholine or doryl. Such a result does not permit the prompt return of the patient to a useful way of life.

2. Vagotomy has given satisfactory results in patients with marginal or jejunal ulcer, especially if a thorough vagus resection is done.

3. An incomplete vagotomy, which may follow even the most careful dissection, plus a gastro-enterostomy, may be followed by a marginal ulcer or by a failure of the duodenal ulcer to heal.

4. Vagotomy is already being used as a means of reducing the extent of the gastric resection. We believe this to be an unsafe procedure.

5. To obtain a good result from an adequate gastric resection one does not require vagotomy.

A number of thousands of ulcer patients have now been partially or completely vagotomized at a level just above or below the diaphragm. There are available data on these patients, and at least one group is collecting these at the national level. We now know that division of the vagi above the stomach provides immediate relief from pain. It does, however, superimpose a condition of delayed gastric emptying in most patients and, in some instances, one of massive gastric retention. In others, an intractable diarrhea results.

Gastric retention, the belching of foul smelling gastric contents, and a persistent feeling of fullness, which so many of our patients have had, are unphysiological conditions which have resulted from a physiological approach to the ulcer problem.

Vagotomy, therefore, must still be looked upon as an experimental operation. For evaluation of its exact usefulness no more operations need be recorded; there have been enough done, but a longer period of follow-up will be necessary and a more careful study of those which have been performed before the role of this procedure can be

properly determined. It should not be used for gastric ulcers or for bleeding duodenal ulcers. It should not be used when pyloric stenosis is already present unless a gastro-enterostomy is done at the same time.

The objective of any operation for ulcer should be to remove the ulcer and to obtain a permanent reduction in free hydrochloric acid secretion. In no other way can surgery offer, at present, a high percentage of cures. Reports are already available of perforation of the ulcer after vagotomy, of return of gastric acid secretion probably from regeneration of the vagi, of return of an ulcer which had healed promptly after vagus resection. We have observed all these complications in a very careful study of a relatively small group of patients. The initial enthusiasm which greeted the advent of vagotomy should now be tempered by an attitude of cautious questioning. It is useful in the treatment of stomal ulceration. Whether it will prove to be better than gastrectomy for the other complications of duodenal ulcer or even as good remains for the future to tell. I venture to state that it probably will be used with less and less frequency as the years go by.

I have reviewed what we consider the important indications for operation in gastric and duodenal ulcer and have in general indicated the type of procedure we have found best suited for each condition requiring operation. While a correctly selected procedure and a skillfully done operation will do much to reduce morbidity and mortality, the pre- and post-operative care of ulcer patients is of the greatest importance. In perforation and hemorrhage any extensive period of preparation may prove fatal, but, in obstruction and intractability, a period of preparation will markedly reduce morbidity and mortality regardless of the operation which is done.

Many of these patients come for aid, as I have already intimated, after long periods of under-nutrition. They are frequently dehydrated from vomiting and fluid restriction. They are deficient in a number of the vitamins, especially the B complex and C, and there is present in many of them a deficiency in the blood and plasma volume and in the labile protein stores.

In patients with evidence of complete or incomplete pyloric obstruction we at once institute suction drainage after the method of Wangensteen and Paine. Nothing assists so much in overcoming the edema surrounding the obstruction as putting the stomach at rest by keeping it empty. The fluid

and salt balance are restored by the judicious administration of blood and fluids. Each patient is treated as a specific problem whose specific deficiencies are connected by a carefully designed program of therapy.

Edema around the suture line from the trauma of operation is greatly increased in the presence of hypoproteinemia. Many patients have been subjected to secondary operations for a supposed mechanical defect of the operation when in reality the obstruction at the site of the new stoma was due to edema, the result of a profound biochemical disturbance. It should be remembered that in the presence of low plasma protein the administration of large amounts of sodium chloride will still further increase edema especially at the operative site. The postoperative care of these handicapped patients requires a working knowledge of the processes involved in keeping fluids in the blood vessels.

Regardless of the size of the new stoma and regardless of the presence or absence of hypoproteinemia some edema occurs along the line of suture, and gastro-intestinal motility is not normal for some days after operation. Edema can be reduced by the judicious use of parenteral fluids and salt, by the gentle handling of tissues, the avoidance of clamps, and finally by minimal inversion of tissue at the site of the new stoma. If this is done, early feeding by mouth of a solid diet is well tolerated, and convalescence is hastened by the adoption of early rising.

The surgeon in considering operation for a gastric or duodenal ulcer must, as Roscoe Graham has so well said, "Take into consideration (1) the site of the ulcer; (2) the character of the pathological lesion; (3) the associated physiological disturbances; (4) the resultant biochemical disturbances; (5) the age of the patient." When the patient accepts the decision that surgical therapy offers the best chance for cure, he should expect: (1) an excellent chance of recovery from the operation; (2) relief from symptoms; (3) reasonable assurance against recurrence; and (4) ability to return to his usual work.

We believe these objectives can best be met by a radical gastric resection which should, if possible, include the ulcer-bearing area. At this time, based upon our experience with vagotomy, we believe it should be reserved for use in the treatment of stomal ulcers following gastro-enterostomy and gastrectomy. Next month or next year additional data may lead us to extend the indications for its use.



PRESENT-DAY STATUS OF TESTS OF HEPATIC FUNCTION*

HUGH R. BUTT, M.D.†

ROCHESTER, MINNESOTA

AS early as 1862 Austin Flint¹ described a new excretory function of the liver, depending upon removal of cholesterol from the blood and its discharge from the body. Since then physiologists have warned repeatedly that since the liver has many functions and a great capacity for recovery that no one test of hepatic function could be depended upon to indicate the general status of the whole organ. In spite of this, clinicians and surgeons are still hopefully looking for one magic test of hepatic function. It is rather obvious, however, that all the functions of this organ cannot be measured and, even with the large number of tests currently proposed, the difficulties that arise in interpretation are manifold. Naturally, many tests of hepatic function have been proposed and widely used, and many discarded, but none to date has proved to be absolutely dependable under all circumstances.



These tests of hepatic function have been divided, for purposes of discussion, into groups. They will be presented as tests of excretory function, as those concerned with specific metabolic functions of the liver and as those dependent on alterations in the plasma proteins.

As clinicians and surgeons we are interested in tests of hepatic function for two primary reasons: first, as an aid in estimating the general state of function of the organ and, second, as an aid in the differential diagnosis of jaundice. In this report, those tests of hepatic function which are in common use will be discussed, and comment on the theoretic phases involved will be limited to a minimum.

EXCRETORY FUNCTIONS

Bilirubin. The liver has many excretory functions, chief of which is the excretion of bile. The

liver acts as an excretory organ for bilirubin just as the kidney does for urea. Increases in serum bilirubin can be, in general, attributed to three types or combinations of disturbances: (1) those in which bilirubin is produced in excess of the capacity of the liver to excrete it (hemolytic jaundice), (2) those in which the hepatic cells and finer bile passages are injured (hepatitis), and bile accumulates in the blood stream, and (3) those in which there is obstruction to the larger bile passages, causing a reflux of bile into the blood (obstructive jaundice).

It is obvious that a measure of the serum bilirubin will provide useful information with regard to the functional status of the liver. For the measure of the intensity of jaundice the quantitative van den Bergh test is preferable to the icterus index. The color produced in the van den Bergh test results from a chemical reaction between the bilirubin and Ehrlich's diazo reagent. Thus, errors can be avoided which may occur in the simple matching of serum with potassium dichromate standard used in determining the icterus index. When laboratory facilities are very limited, the methylene blue test for "bilirubin" in the urine may serve as a useful although less accurate indicator of the course of the jaundice.²

The van den Bergh test, as usually employed, measures the total bilirubin present and its reaction (direct or indirect). One may consider, for practical purposes, that normal serums always give the "indirect" reaction and bilirubin may exist in amounts varying from 0.5 to 1.0 mg. per 100 cc. In the hemolytic anemias the excess of bilirubin gives an indirect reaction. The liver has an enormous reserve in its capacity to excrete bile pigment and many believe that jaundice rarely develops from overproduction of pigment alone but is due to a combination of overproduction of pigment and functional impairment of the hepatic cells.³ When the serum shows direct-reacting bilirubin it is good proof of injury to the hepatic cells. Details of the physiologic factors involved have been well reported elsewhere.⁴

* Presented at the General Meeting of the Indiana State Medical Association, at the annual convention in Indianapolis, on October 28, 1948.

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3. Rich, A. R.: The Pathogenesis of the Forms of Jaundice, *Bull. Johns Hopkins Hosp.*, **47**:338-377. (Dec.) 1930.

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For practical purposes then, according to Snell and Magath,⁵ one may expect a direct van den Bergh reaction in about 80 percent or more of cases in which there is a moderate degree of hepatic injury. The height of elevation of the serum bilirubin alone is not often of much value in the differentiation of obstructive and nonobstructive jaundice. The higher values for serum bilirubin (25 to 50 mg. per 100 cc.) are found usually in acute and severe forms of hepatitis and in malignant obstruction of the biliary duct. The intermediate values are observed most often in milder degrees of hepatogenous icterus and with intermittent or partial obstruction of the bile duct. The lower values for direct-reacting bilirubin ordinarily are seen in subsiding hepatitis and in chronic forms of hepatitis which may follow obstruction of the biliary tract or in portal cirrhosis and the like.

The daily variation in the value for serum bilirubin may also be of great aid in diagnosis. A rapidly rising value for serum bilirubin which reaches a plateau may often signify biliary obstruction due to neoplasm. In cirrhosis or chronic hepatitis seen with stricture of, or stone in, the common bile duct, a low plateau curve of bilirubin often is observed. Acute hepatitis often produces a rapid rise in the values for bilirubin and frequently an equally rapid fall. In chronic hepatic disease, low and irregular curves are the rule. In general, falling levels of serum bilirubin suggest restored patency to the bile ducts, or a liver which is undergoing rapid repair. High or rising levels of bilirubin most frequently signify complete obstruction of the bile ducts, rapid degeneration of the hepatic parenchyma, or a combination of the two.

Urobilinogen. Bile pigment entering the colon is acted upon by bacteria and converted into urobilinogen. Most of the latter is, under ordinary circumstances, excreted in the stool and is oxidized to urobilin. A portion, however, is absorbed through the intestine and brought to the liver by the portal circulation, being re-excreted in the bile. A very small fraction of the absorbed urobilinogen passes through the liver to the hepatic veins, enters the general circulation and eventually is excreted by the kidneys.

It follows, therefore, that if the hepatic cells are injured the handling of urobilinogen is interfered with and a larger amount will be excreted in the urine. It is equally obvious that if the bile ducts are obstructed and no bilirubin reaches the bowel, then no urobilinogen can be formed in the stool.

The determination of urobilinogen in twenty-four-hour samples of feces is "still another way to gauge" the patency of the bile passages. Watson's short method for measuring urobilinogen may be

used.⁶ Urobilinogen in an amount of 50 to 300 Ehrlich units is found in a normal twenty-four-hour sample of feces. Values in the range of from 0 to 10 units mean either complete obstruction or temporary suppression of secretion. Repeated analyses must be done during the period of observation in order to establish the existence of complete obstruction. The persistent absence of bile from the duodenum and values for fecal urobilinogen persistently in the range seen in complete obstruction usually mean malignant obstruction.

Retention of Dye. The injection of certain dyes into the blood stream and measurement of their excretion by the liver always has been a favored type of test. Only two, rose bengal and sulfobromophthalein (bromsulfalein), ever came into common use. Because of the difficulties of the test, the rose bengal test rarely is used today. Therefore, the dye most frequently employed to determine hepatic function is sulfobromophthalein. In the absence of obstruction to the bile passages, this dye is excreted by the liver specifically, although perhaps not quantitatively. A test with this dye, perhaps, is the most satisfactory test for hepatic function in the absence of jaundice that has yet been devised. The laboratories at the Mayo Clinic inject 5 mg. of the dye per kilogram of body weight and remove a single specimen of blood at the end of one hour. The amount of dye present in the serum is determined by comparison with standard tubes in a colorimeter. The results of this simple test are very satisfactory. Retention of dye occurs in about 96 percent of patients with evidence of hepatic injury who have no clinically demonstrable jaundice.⁷ Low-grade retention of the dye (less than 12 percent) also is important, since in this group it frequently is not possible to recognize hepatic disease. Sometimes low-grade retention occurs without evidence of hepatic disease but this is rare. Of course, marked retention is the rule with cirrhosis of the liver, Banti's disease and many other chronic hepatic diseases. Recently, in a study of the comparative value of certain hepatic functional tests, Neefe and Reinhold⁸ have reported that even in early (pre-icteric) infectious hepatitis the sulfobromophthalein retention test was the first test to provide evidence of the initial hepatic disturbance. Although during the convalescent stage of the infectious hepatitis, the dye retention test was perhaps of least value, yet

5. Snell, A. M.; and Magath, T. B.: The Use and Interpretation of Tests for Liver Function: A Clinical Review, *J. A. M. A.*, **110**:167-174. (Jan. 15) 1938.

6. Watson, C. J.; Schwartz, S.; Sborov, V.; and Bertie, Elizabeth: Studies of Urobilinogen; A Simple Method for the Quantitative Recording of the Ehrlich Reaction as Carried Out with Urine and Feces, *Am. J. Clin. Path.*, **14**:605-615. (Dec.) 1944.

7. Magath, T. B.: The Takata-Ara Test of Liver Function, *Am. J. Digest. Dis.*, **2**:713-716, (Feb.) 1936.

8. Neefe, J. R.; and Reinhold, J. G.: Laboratory Aids in the Diagnosis and Management of Infectious (Epidemic) Hepatitis; Analysis of Results Obtained by Studies on 34 Volunteers During the Early and Convalescent Stages of Induced Hepatitis, *Gastroenterology*, **7**:393-413. (Oct.) 1946.

it has been found to be of particular value in detecting relapses of hepatitis.^{9, 10}

METABOLIC TESTS

Akaline Phosphatase. It was Roberts¹¹ who first noted that high values for phosphatase in the serum occurred in some cases of obstructive jaundice, while in nonobstructive types the values were often normal or low. Some writers consider it to be the most sensitive indicator of obstruction in the biliary passages;¹² others find that relatively high values are sometimes observed in primary parenchymal injury. Certainly, limitations are imposed on its use as an indicator of biliary obstruction, since in certain skeletal disorders, growing children, and so forth, there are increased and varying levels of serum phosphatase.¹³ Nevertheless, at times this test, when properly interpreted, is a useful aid in the differential diagnosis of jaundice.

Cholesterol and Cholesterol Esters. In normal blood serum, esterified cholesterol makes up 50 to 70 percent of the total cholesterol. In obstructive jaundice there often is a rise in the total serum cholesterol and since esterification keeps pace with this change the cholesterol esters usually remain within normal range. In parenchymatous jaundice there is no striking change in the value for total cholesterol but esterification frequently is impaired and value for cholesterol esters is lowered.¹⁴ In our experience, if biliary obstruction has been of long duration the cholesterol content of the plasma may be normal or decreased. In the ordinary type of cirrhosis, values for cholesterol and cholesterol esters are, as a rule, normal. It has been thought by many that very low values for cholesterol esters indicate rather severe hepatic damage. Certainly, with values of 30 mg. per 100 cc., or lower, one would be correct in assuming that such severe damage is present. Unfortunately, however, there seem to be many exceptions to this rule.

Galactose and Levulose. Both galactose and levulose are specifically metabolized by the liver. Galactose is utilized apparently only very slightly, if at all, by other tissues. The value of determination of galactose in the differential diagnosis of jaundice depends upon the fact that the liver does not lose its ability to metabolize this sugar even in the presence of long-continued obstructive jaundice. Certainly the conventional test in which the galactose is given orally has proved to be unreliable. There is some evidence that the test, when the galactose is administered intravenously, is useful in the differential diagnosis of obstructive versus intrahepatic jaundice.¹⁵ Extensive and comparative studies using this method have not been reported.

Because of the difficulties and errors involved, the levulose test has, for the most part, been discarded in most institutions.

Hippuric Acid. This test is based upon the ability of the liver to conjugate benzoic acid and amino-acetic acid to form hippuric acid. This test was brought into favor by Quick¹⁶ and it has enjoyed considerable support. It is, however, time-consuming and certain factors such as renal injury, dehydration and malnutrition affect the final results. For these reasons my colleagues and I no longer employ this procedure.

BLOOD AND COAGULATION FACTORS

Erythrocytes. The change in the appearance of the erythrocytes cannot be described as a test of hepatic function. These changes, however, should be mentioned. A macrocytic anemia is a not uncommon finding in portal cirrhosis and is sometimes noted in hepatitis and other forms of hepatic disease. Such changes are sometimes rapid and the exact factors responsible are not yet completely known.

Prothrombin. It is now well known that obstructive jaundice, by interfering with the proper absorption of vitamin K, often is accompanied by a deficiency in the blood prothrombin. Furthermore, it is common knowledge that this deficiency of prothrombin can usually be corrected within a few hours by simply giving the patient vitamin K.

Parenchymatous jaundice also is frequently accompanied by a deficiency of prothrombin. In this instance, the deficiency apparently is due to some interference in the ability of the liver to fabricate prothrombin and not to a deficiency of vitamin K. Thus, the administration of vitamin K either does not raise the level of prothrombin in the blood at all, or it raises it very slowly and even then the level of prothrombin often decreases in spite of the continued administration of vitamin K.

9. Kunkel, H. G.; Labby, D. H.; and Hoagland, C. L.: Chronic Liver Disease Following Infectious Hepatitis. I. Abnormal Convalescence from Initial Attack, *Ann. Int. Med.*, **27**:202-219. (Aug.) 1947.
10. Watson, C. J.; and Hoffbauer, F. W.: Liver Function in Hepatitis, *Ann. Int. Med.*, **26**:813-842. (June) 1947.
11. Roberts, W. M.: Variations in the Phosphatase Activity of the Blood in Disease, *Brit. J. Exper. Path.*, **11**:90-95. (Apr.) 1930.
12. Shay, Harry; and Siple, H.: Minimal Yet Adequate Program of Liver Function Studies in the Differential Diagnosis of Jaundice, *Am. J. Med.*, **4**:215-227. (Feb.) 1948.
13. Gutman, A. B.; Olson, K. B.; Gutman, Ethel B.; and Flood, C. A.: Effect of Disease of the Liver and Biliary Tract Upon the Phosphatase Activity of the Serum, *J. Clin. Investigation*, **19**:129-152. (Jan.) 1946.
14. Epstein, E. Z.; and Greenspan, E. B.: Clinical Significance of the Cholesterol Partition of the Blood Plasma in Hepatic and Biliary Diseases, *Arch. Int. Med.*, **58**:860-890. (Nov.) 1936.

15. Giansiracusa, J. E.; and Althausen, T. L.: Diagnostic Management of Patients with Jaundice, *J. A. M. A.*, **134**:589-594. (June 14) 1947.
16. Quick, A. J.: The Synthesis of Hippuric Acid: A New Test of Liver Function, *Am. J. M. Sc.*, **185**:630-635. (May) 1933.

This difference in response of the level of prothrombin to the administration of vitamin K is, at times, most helpful in the differential diagnosis of jaundice. In a recent report of 86 cases of obstructive jaundice with a decreased level of prothrombin, 91 percent of the patients responded to a single 1 mg. dose of vitamin K, given intravenously, with a significant increase in the level of prothrombin.¹⁷ Although it has been reported that a pronounced increase in the level of prothrombin is the rule in biliary obstruction, whereas little or no response occurs in primary hepatic injury,¹⁸ such is not always the case.

ALTERATIONS IN PLASMA PROTEIN

Serum Protein. Normal human serum has a total protein content of about 7.5 gm. per 100 cc. From 60 to 65 percent of this protein is the albumin fraction and the remaining 30 percent is composed of the alpha, beta and gamma globulins. It has been known for many years that the total protein content of the serum in patients with hepatic disease may be normal, increased or decreased. Often the decrease in protein is in the albumin fraction, and an increase in either the beta or gamma globulin fractions may occur. The total protein seldom is altered greatly in obstructive jaundice unless it is of long standing. In parenchymatous jaundice, low values for protein are not uncommon, particularly the low albumin and high globulin values. The low value for total protein often seen with ascites and cirrhosis is well known.¹⁹ Recently,²⁰ it has been reported that the albumin-globulin ratio, as measured by fractionation with methyl alcohol, was consistently depressed in hepatic disease and that it might be utilized with profit as a test of hepatic function.

Many tests of hepatic function have been devised which are based on derangement in formation of the serum proteins. These derangements, until very recently, were only vaguely understood.²¹ These alterations can now be somewhat described quantitatively by measuring the protein fractions

as separated electrophoretically in the Tiselius apparatus. The most recent additions to this long list of tests of hepatic function are the so-called flocculation tests, which will be discussed below.

Takata-Ara Test. This test is a colloidal reaction performed on the blood serum. It has been proved to be of little value, with many false positive results, and need not be further discussed.

Colloidal Gold Test. This test was applied to hepatic disease by Gray.²² There is evidence that change in the individual globulin fractions, particularly in the euglobulin fraction, plays an important role in the precipitation of colloidal gold. Although this test is thought by some to be of definite value in the diagnosis of hepatic disturbances^{23,24,25}, yet it is a difficult procedure and not too suitable for routine clinical use. Its value is greatest as an aid in the differential diagnosis of jaundice.

Cephalin-Cholesterol Flocculation Test. This rather simple test was first described by Hanger²⁶ in 1938. It depends on the capacity of the blood serum to flocculate a colloidal suspension of cephalin-cholesterol complex. A negative test is one in which no flocculation occurs. Apparently, the flocculation-inhibiting action of normal blood serum is a function of the albumin fraction²⁷ and not the gamma globulin fraction, as previously thought.

The value of this test in parenchymatous jaundice is well established.²³ It often shows a prolonged elevation during convalescence from infectious hepatitis after signs or symptoms of the disease have ended. Unfortunately, it often gives a positive result in obstructive jaundice and is not too useful in the differential diagnosis of jaundice. The test gives no index to the severity of the hepatic damage and should not be termed a test of hepatic function.

Thymol Turbidity Test. This test was discovered by Maclagan.²⁸ A simple mixture of blood serum

17. Althausen, T. L.: Liver Function Tests in the Differential Diagnosis of Jaundice, *Am. J. Med.*, **4**:208-214. (Feb.) 1948.
18. Lord, J. W., Jr.; and Andrus, W. DeW.: Differentiation of Intrahepatic and Extrahepatic Jaundice: Response of the Plasma Prothrombin to Intramuscular Injection of Menadione (2-methyl-1, 4-naphthoquinone) as a Diagnostic Aid, *Arch. Int. Med.*, **68**:199-210. (Aug.) 1941.
19. Butt, H. R.; Snell, A. M.; and Keys, Ancel: Plasma Protein in Hepatic Disease: A Study of the Colloid Osmotic Pressure of Blood Serum and of Ascitic Fluid in Various Diseases of the Liver, *Arch. Int. Med.*, **63**:143-155. (Jan.) 1939.
20. Kibrick, A. C.; and Clements, A. B.: A comparative Study of the Serum Albumin-Globulin Ratio, the Cephalin-Cholesterol Flocculation, and the Thymol Turbidity Tests for Liver Function, *J. Lab. & Clin. Med.*, **33**:662-671. (June) 1948.
21. Gray, S. J.; and Barron, E. S. G.: The Electrophoretic Analyses of the Serum Proteins in Diseases of the Liver, *J. Clin. Investigation*, **22**:191-200. (Mar.) 1943.
22. Gray, S. J.: The Colloidal Gold Reaction of Blood Serum in Diseases of the Liver, *Arch. Int. Med.*, **65**:524-544. (Mar.) 1940.
23. Havens, W. P., Jr.; and Marck, Ruth E.: A Comparison of the Cephalin-Cholesterol Flocculation and Thymol Turbidity Tests in Patients with Experimentally Induced Infectious Hepatitis, *J. Clin. Investigation*, **25**:816-821. (Nov.) 1946.
24. Neeffe, J. R.: Results of Hepatic Tests in Chronic Hepatitis without Jaundice; Correlation with the Clinical Course and Liver Biopsy Findings, *Gastroenterology*, **7**:1-19. (July) 1946.
25. Rennie, J. B.; and Rae, S. L.: Differential Diagnosis of Jaundice by Flocculation Tests, *Brit. M. J.*, **2**:1030-1032. (Dec. 27) 1947.
26. Hanger, F. M.: The Flocculation of Cephalin-Cholesterol Emulsions by Pathological Sera, *Tr. A. Am. Physicians*, **53**:148-151. 1938.
27. Moore, D. B.; Pierson, P. S.; Hanger, F. M.; and Moore, D. H.: Mechanism of the Positive Cephalin-Cholesterol Flocculation Reaction in Hepatitis, *J. Clin. Investigation*, **24**:292-300. (May) 1945.
28. Maclagan, N. F.: The Thymol Turbidity Test as an Indicator of Liver Dysfunction, *Brit. J. Exper. Path.*, **25**:234-241. (Dec.) 1944.

with a saturated solution of thymol in a barbitone buffer of pH 7.8 is used. The degree of turbidity that develops in one-half hour is compared with the turbidity of the formazin standards (used for years in rough quantitative determinations of protein in the urine). Normal serums usually give readings of 0 to 4 units. Increased values usually are present in intrahepatic jaundice and values of "O" in obstructive jaundice. The underlying mechanisms responsible for this test depend on changes in the serum lipids, the lipoprotein complexes and the gamma globulin fraction of the serum.²⁹

During the course of infectious hepatitis, values obtained with this test show a delayed rise following the onset of the disease and a prolonged elevation during convalescence. It does not often give positive results in obstructive jaundice and, for this reason, is most useful in the differential diagnosis of jaundice. It, like the cephalin-cholesterol flocculation test, is not a test of hepatic function; it is instead a sensitive indicator of acute hepatic damage and, in view of the variety of diseases which will give a positive reaction, one might attribute the reaction to the even more general phenomenon of reticulo-endothelial irritation.³⁰ In agreement with previous reports, my colleagues and I have found the thymol turbidity reaction to be usually positive in infectious hepatitis but usually negative in biliary obstruction of diverse types. In a mixed group of cases of cirrhosis, an approximately equal tendency toward positive and negative reactions was observed.^{31, 32}

Serum Gamma Globulin Test. This turbidimetric test was recently described by Kunkel³³ and depends on increases in gamma globulin alone. The test has not been employed widely but the reaction appears to be usually positive in primary hepatic injury and negative in obstructive jaundice. It is a simple test to perform and, because of standard solutions, is easily reproducible. For these reasons it will undoubtedly come into favor.

COMMENT

It is common knowledge that laboratory tests are valuable supplements to, but no substitutes for,

29. Kunkel, H. G.; and Hoagland, C. L.: Mechanism and Significance of the Thymol Turbidity Test for Liver Disease, *J. Clin. Investigation*, **26**:1060-1071. (Nov.) 1947.
30. Kunkel, H. G.: Value and Limitations of the Thymol Turbidity Test as an Index of Liver Disease, *Am. J. Med.*, **4**:201-207. (Feb.) 1948.
31. Mann, F. D.; Snell, A. M.; and Butt, H. R.: The Thymol Turbidity Test and Impaired Liver Function, *Gastroenterology*, **9**:651-655. (Dec.) 1947.
32. Butt, H. R.; and Baggenstoss, A. H.: Problems Encountered in the Diagnosis of Serum and Infectious Hepatitis, *S. Clin. North America*, **27**:926-944. (Aug.) 1947.
33. Kunkel, H. G.: Estimation of Alterations of Serum Gamma Globulin by a Turbidimetric Technique, *Proc. Soc. Exper. Biol. & Med.*, **66**:217-224. (Oct.) 1947.

TABLE 1
TESTS OF HEPATIC FUNCTION IN JAUNDICE

Test	Jaundice	
	Obstructive	Hepatocellular
Alkaline phosphatase	Increased	Normal
Thymol turbidity	Negative	Positive
Cephalin-cholesterol flocculation	Negative	Positive
Kunkel turbidity	Normal	Increased
Response of prothrombin to vitamin K	Prompt	Delayed or absent

a well-taken history and a thorough physical examination. Tests of hepatic function are no exception to this rule. The intelligent interpretation of these tests depends, of course, upon a thorough understanding of the underlying physiologic principles. Further, the interpretation depends upon the knowledge of the sources of error in the method and on the skill and reliability of the person collecting the specimens and performing the tests.

There is little doubt that the clinical differentiation between obstructive and parenchymatous icterus can be made frequently. Often, however, it is impossible to do so despite a careful history and physical examination. Certainly, the age of the patient, the presence or absence of pain and pruritus, the degree of jaundice, loss of weight and the like, are all important factors, but experience has too often shown that these features cannot always be relied on in making the differential diagnosis in a given case. It is at this point that some of the tests discussed above are often useful.

Studies of hepatic function too often, perhaps, are concerned with a comparison of one test with another and an attempt to establish their respective superiority. More important would be the study of their value in differentiating between the types of jaundice. Exploration in a patient with parenchymatous disease of the liver is still a very serious error, and any diagnostic procedure that might prevent such an occurrence should be carefully evaluated.

The importance of the measurement of bilirubin in the blood serum and the reliability of the sulfobromophthalein test in nonjaundiced patients are well recognized. Duodenal drainage and urobilinogen studies for determining the patency of the bile ducts are without peer. In Table 1 are shown the more recent tests which have, if properly interpreted, been found to be most useful in the differential diagnosis of jaundice. With the exception of the response of prothrombin to vitamin K, none are tests of hepatic function. Rather, they represent chemical alterations which may occur in the presence of injury to the liver. This, of course, is not meant to imply that they do not have uses and value. In our experience to date at the clinic,

the alterations in the results of the thymol turbidity test and the Kunkel test have represented the most consistent differences between obstructive jaundice and hepatitis as observed in the laboratory. The concept, however, that these procedures are specific indicators of hepatic function leads to misuse of the test.

SUMMARY

In the above paragraphs an attempt has been made to present the present-day status of hepatic functional tests. None is without fault, but few doubt that these procedures are of definite clinical value. They are of value only, however, when used with much scrutiny and knowledge of their very definite limitations.

PRIMARY TULAREMIC PNEUMONIA
TREATED WITH STREPTOMYCIN

REPORT OF CASE

STEPHEN L. JOHNSON, M.D.

EVANSVILLE

THIS single case of pulmonary tularemia treated with streptomycin is being reported because it seems to have been of primary inhalation origin.

Pulmonary tularemia has been seen with increasing frequency in recent years. Verbrycke¹ in 1924 reported its presence at autopsy in a case with general distribution of the disease. Permar and MacLachlan² in 1931 studied the twenty-five fatal cases of tularemia then in the literature and found pulmonary involvement in nine of them. The reported cases have been periodically collected since that time. Stuart and Pullen³ reviewed the literature in 1945 and collected 268 cases, including fifteen of their own. Hunt⁴ in 1947 reported an additional fifteen cases.

It appears that pulmonary involvement (until recently) was considered to be always an incident in a severe typhoidal type of case. It has been generally accepted, and remained difficult to refute, that absence of a primary lesion and superficial lymphadenitis were the result of such massive infection as to overwhelm the local defenses, with the result that these manifestations were lacking. Permar and MacLachlan² felt that primary lung infection might have occurred in several of the cases they studied. Aagaard⁵ has reported one case in which an infected rabbit sneezed in the face of the victim. The concept of a primary pneumonic form has appealed to several students³ as logical because of similarities to tuberculosis

and plague. Blackford and Casey⁶ write "Two routes by which *Bacillus tularensis* may reach the lung have been discussed. Reiman (The Pneumonias) has summarized the possibilities as follows: 'In this (general systemic) form the lungs are often invaded by way of the blood stream and pneumonia occurs as a concomitant localization. In the rare primary pulmonic form, as in plague, infection is apparently acquired by inhaling bacilli suspended in air as dust, or in droplets expelled from patients or animals who have tularemic pneumonia, or from handling dried cultures of the bacteria.'" They continue and express what seems to be generally accepted: "... infection through inhalation has not been proved and is extremely rare if it ever occurs. The failure to find a portal of entry does not mean that the organisms entered through the respiratory tract."

In their review of agents available for bacteriological warfare, Rosebury and Kabat⁷ mention *B. tularensis* but are not convinced as to its infectivity by inhalation. Since this article was written in 1942 it would be extremely interesting to know if further study has clarified this point experimentally.

A positive blood culture known to precede the respiratory symptoms would be presumptive evidence that the lungs had been involved secondarily. A good history of direct respiratory exposure might be considered evidence for a primary inhalation infection, as might isolation of bacilli from sputum while the blood culture remained negative.

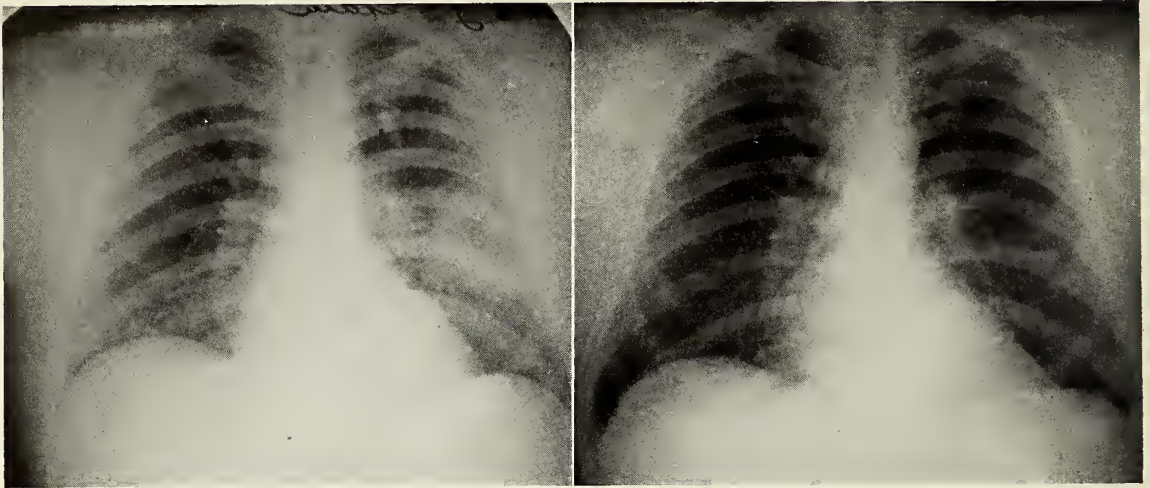
CASE REPORT

A 34-year-old, white male was admitted to the hospital on November 21, 1946. His past history

1. Verbrycke, J. R., Jr.: Tularemia. *J. A. M. A.*, 82: 1577, May 17, 1924.
2. Permar, H. H., and MacLachlan, W. W. G.: Tularemic Pneumonia. *Ann. Int. Med.*, 5:687, Dec., 1931.
3. Stuart, B. M. and Pullen, R. L.: Tularemic Pneumonia. *Am. J. Med. Sc.* 210:223, Aug., 1945.
4. Hunt, J. S.: Pleuropulmonary Tularemia. *Ann. Int. Med.*, 26:263, Feb., 1947.
5. Aagaard, G. U.: Involvement of Heart in Tularemia. *Minnesota Med.*, 27:115, Feb., 1944.

6. Blackford, S. D. and Casey, C. J.: Pleuropulmonary Tularemia. *Arch. Int. Med.*, 67:43, Jan., 1941.
7. Rosebury, T. and Kabat, E. A.: Bacterial Warfare. *J. of Immunology*, 56:7, May, 1947.

Figure 1



X-ray on left taken on sixth day of illness. (Portable, bedside.) X-ray on right, taken eight months later, shows clearing in lung and obliteration of costophrenic sinus.

and family history were not significant. On November 16, five days before admission, the patient developed high fever, with flushed face, headache and generalized aching. Nausea appeared in the first twenty-four hours. Cough had been present since onset of the illness and became productive of purulent sputum. There had been no pleuritic pain. The fever continued high and there was marked prostration. Coughing was often followed by vomiting. The patient had dressed rabbits barehanded on November 11 and 16 and had hunted in the rain most of latter day.

Physical examination: Patient was a large, well-muscled, thick-chested man who appeared very acutely ill. Temperature 104.6; pulse 112; respiration 24; blood pressure 140/80. Face was quite flushed. There was a moderate conjunctivitis; pupillary reactions were normal. Nose and throat were congested. Examination of the ears showed some reddening of Shrapnell's membrane. Lungs showed equal expansion with a good percussion note and normal breath sounds everywhere. Heart was rapid, apparently of normal size, with a regular rhythm and good tones. The abdomen was not remarkable. The patient was clear mentally, there was no neck rigidity, and no abnormal leg signs were present. Deep reflexes were all sluggish, but plantar response was normal. There were no enlarged lymph glands.

Laboratory work on admission: Rbc. 4,640,000; hgb. 13.5 gms.; Wbc. 11,900, Neutrophils 87% with 13 Stabs; Lymphs. 11; Monos. 2. Urinalysis: Sp. gr. 1.017; Albumin 3+; Sugar, negative; Acetone, 3+; Casts, 5 per low power field. Smear of the sputum showed mixed organisms with staphylococcus and streptococcus predominating. Blood Kahn was negative. X-ray on admission

showed a pneumonitis of the left lung in the periphery at level of 3rd, 4th and 5th ribs, anteriorly. Despite the unusual blood picture this was considered to be an influenzal infection. The patient's condition rapidly became worse and marked stridor developed over most of the left lung. The initial treatment was oxygen under a tent, intravenous Amigen, and penicillin because of mixed organisms in sputum. The absence of any peripheral sores or palpable lymph glands kept tularemia out of consideration for three days. During that time his temperature still reached 104 daily and his condition remained critical.

The history of his contact with rabbits was then reviewed and one new detail brought out. On November 11, ten days before his admission and five days before the acute onset, he had chased a rabbit into the base of a hollow tree. In trying to beat the rabbit out through a hole in the tree he had stirred up a heavy dust which he breathed for some length of time. He remembered that he had sneezed at the time. This suggested that he might have acquired a primary inhalation exposure to tularemia. Agglutination set up for tularemia at that time (ninth day of illness) was reported as complete in 1 to 200 dilution. The patient was then placed on streptomycin at two grams per day. On the first day his temperature rose to 105 (R) and then began to fall gradually. During the first few days of this treatment his physical signs spread to the left lung base, but symptomatic improvement was almost immediate. His agglutination titre was reported positive at 1:400 on the thirteenth day and 1:800 on the seventeenth day. His blood count dropped to 3,800,000 red cells and 11 gms. of hemoglobin. His chest x-ray showed diminished consolidation

before discharge. He received eleven grams of streptomycin in six days.

He was discharged from the hospital fourteen days following admission, on the twentieth day of his illness, with a normal temperature and feeling good.

Patient was seen for a re-x-ray of the chest eight months later. His pneumonia had cleared except for a fine band of fibrosis but there was an obliteration of the costophrenic sinus, suggestive of pleural involvement not indicated in earlier films.

TREATMENT

The treatment of tularemia has recently had its first real advance with the successful use of streptomycin. Neither sulfonamides nor penicillin have proved of value. Specific immune serum has had some value but the results have not been striking. The first reported use of streptomycin in tularemia came from Foshay and Pasternack.⁸ Reports of treatment of one or two cases followed this.⁹ Hunt⁴ in 1947 reported the treatment of twelve cases of pulmonary or pleural tularemia with streptomycin, with eleven cures, and one death on the seventh day of treatment, apparently from pulmonary embolism. The dose ranged from 2.5 grams in five days, leading to a delayed recovery, to a maximum of 8 grams in seven days.

The two cases reported by Atwell and Smith⁹ received 29.5 and 13 grams, respectively. The most recent study on dosage of streptomycin in tularemia was that of Foshay,¹⁰ indicating the adequacy of very small doses, such as 3 grams given over a period of six days.

The effect of streptomycin is on the toxicity of these patients. The x-ray improvement does not follow the clinical one. Indeed, pleural effusion may first appear while the patient is apparently recovering and may be quite persistent. The patient here reported showed no pleural involvement in his primary film or during check-up films while in the hospital, but his follow-up film eight months later showed some obliteration in the left costophrenic angle.

SUMMARY

A case of pulmonary tularemia is reported because there is good reason to believe that the infection was of inhalation origin since: 1, there was a history of inhalation of potentially infected dust; 2, the patient showed no skin or lymphadenoid involvement; and 3, the time relationships were incompatible with a systemic infection complicated by pulmonary localization. The patient made a rapid recovery following treatment with streptomycin.

8. Foshay, L. and Pasternack, A. B.: Streptomycin in Treatment of Tularemia. J. A. M. A., 130:393, 1946.

9. Atwell, R. J. and Smith, D. T.: Primary Tularemic Pneumonia. South. Med. J., 39:358, Nov., 1946.
10. Foshay, L.: Treatment of Tularemia with Streptomycin. Am. J. Med., 2:467, May, 1947.

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CARDIOVASCULAR SYMPTOMS IN CHRONIC BRUCELLOSIS: RESEMBLANCE TO NEUROCIRCULATORY ASTHENIA*

DAN L. URSCHER, M.D.

MENTONE

IN 1942 Davis¹ called particular attention to the presence of precordial pain as a presenting complaint in many patients with chronic brucellosis. Other authors^{2,3,4} had likewise noted the presence of this symptom and others, such as dyspnea and palpitation, which were suggestive of cardiovascular disease in these patients. In a review of 53 cases, published in 1943,⁵ the author reported 19 per cent of the series complaining of chest pain, 17 per cent of palpitation, and 10 per cent of dyspnea. Because of the prominence of these symptoms, and particularly because such patients are sometimes branded with the diagnosis of organic heart disease, it appeared wise to approach the problem from the point of view of a cardiologist, rather than as a "brucellogist."

ORGANIC CARDIAC PATHOLOGY IN BRUCELLOSIS

Except for an occasional case of brucella endocarditis,^{6,7,8} and others the heart appears to be little affected by systemic infection with these organisms. Reports on brucellosis pathology have been infrequent in the literature, except for foreign articles on the disease caused by the melitensis organism. Sprunt and McBryde,⁹ in a very comprehensive review in 1936, found little evidence of cardiac involvement. It would then appear that

the heart is not usually involved in the infectious process, and that the symptoms present must be due to some other effect of the organism on the body.

ACUTE BRUCELLOSIS

Cardiac symptoms were minimal in 10 patients with acute brucellosis analyzed for this presentation. Only 1 patient complained of any substernal distress and she had this prior to the onset of her brucellosis. None of the others had any symptoms referable to the heart, except for occasional mild dyspnea which appeared to be associated with the tiredness which was so prominent. From this small series it seems that, except for the possibility of confusing subacute bacterial endocarditis or acute rheumatic fever with acute brucellosis, there is little chance for diagnostic confusion.

CHRONIC BRUCELLOSIS

Here one encounters a different picture. As may be seen in Table I, 54 per cent (27) of a group of 50 patients complained of one or more symptoms referable to the heart. From this table it may be seen that the three principal complaints were found in about the same number of patients. It is worth-while to note at this time that 20 per cent complained of all three: precordial pain, dyspnea, and palpitation. In other words, in addition to the tiredness so universally found in these patients, this group of ten had most of the symptoms which point toward organic heart disease. However, two other prominent signs of cardiac disorder, edema and orthopnea, were not present in any patient.

TABLE I
Cardiac Symptoms Noted in 50 Patients with
Chronic Brucellosis

	No. cases	%
Pain, dyspnea, or palpitation-----	27	54
Precordial pain, alone, or in combination -----	17	34
Dyspnea, alone, or in combination-----	19	38
Palpitation, alone, or in combination--	19	38
Palpitation alone -----	3	6
Pain alone -----	4	8
Palpitation and dyspnea-----	5	10
Palpitation and pain-----	1	2
Dyspnea and pain-----	2	4
All three in combination-----	10	20

* From a Scientific Exhibit prepared for the Annual Session of the Indiana State Medical Association, French Lick, October 28, 29, and 30, 1947.

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The character and location of the precordial pain is of great importance in the diagnosis. In only 1 patient was the distress truly substernal, and in her it was not associated with exertion. The pain was characteristic of that seen in neurocirculatory asthenia, transitory, sharp, stabbing, most prominent in the region of the left nipple, not exertional. This latter characteristic was carefully investigated, inasmuch as true angina pectoris caused by coronary insufficiency is almost always characterized by distress which is initiated or made worse by exertion, anger, or anxiety, and is relieved by removal of the irritating cause. In neurocirculatory asthenia, on the other hand, pain is more likely to occur when the patient is sitting still, lying down, or standing quietly, and is often relieved by activity. It was this type of pain which was commonly seen in these patients with chronic brucellosis. The location of the distress is tabulated in Table II.

TABLE II
Location of Chest Pain in the 17 Patients Who
Complained of this Symptom

Location	No.	%
Substernal	1	5.9
Apex (nipple area)	13	76.4
Indefinite or shifting	3	17.7

Dyspnea is often a difficult symptom to interpret, whether it be in the true organic cardiac patient or in the patient with neurocirculatory asthenia. Anyone, no matter how healthy or in however excellent physical condition, will become dyspneic if he exercises beyond his customary activity. When one considers that these patients with chronic brucellosis are chronically tired and have little ambition or desire to perform many of the usual tasks of life, it is easy to see that one has to be very careful in eliciting symptoms. Each and every one of them would complain of dyspnea on exertion if the questions were pointed in that way. Nineteen patients listed in Table I as having this as one of their entering complaints were therefore those in whom the shortness of breath was more than one would associate with tiredness alone. However in most of these patients the dyspnea was characteristic of that seen in neurocirculatory asthenia, air hunger rather than true exertional anoxemia. Occasionally, on the other hand, a patient complained of dyspnea so definitely exertional that only a thorough cardiac review and a trial of specific brucella therapy served to rule out organic heart disease. One farmer, 38 years of age, came to the office with the principal complaint of dyspnea. Shortness of breath was so severe on mild exertion that he was unable to do any of his customary tasks. He had no anemia. Chest x-ray, electrocardiogram, and physical examination all failed to reveal organic heart disease, and his symptoms cleared promptly with brucella vaccine therapy.

Palpitation is such an indefinite symptom, and one so commonly absent in true organic heart disease unless associated with significant arrhythmias, that it was usually important only from the patient's point of view in this series. In only one patient was it confusing from a diagnostic viewpoint, and in that patient, having attacks of rapid heart action, the diagnosis of true auricular paroxysmal tachycardia was confirmed later. The possible association of this condition with the chronic brucellosis which he had is a matter of some interest, inasmuch as he has had only one attack in the five-year period since he received adequate brucella vaccine therapy. Three of the patients had ventricular premature systoles of which they were conscious, while another had persistent sinus tachycardia of undetermined origin.

ASSOCIATED CARDIAC CONDITIONS

In preparing this paper, almost all of the patients who had organic heart disease and brucellosis were eliminated, for obvious reasons. If they had true organic heart disease, it is apparent that it would be very difficult to determine the role of brucellosis in producing symptoms. The four patients whose conditions are listed in Table III were included in the series because a trial of therapy appeared to show that brucellosis was playing a significant part in their symptomatology.

Because of the selection system used none of these patients had significant cardiac murmurs.

There was x-ray evidence of cardiac enlargement in four patients, one being the man with the luetic aortic aneurysm. In the other three this enlargement was not considered to be of significant degree.

It had been the author's clinical impression that hypotension was fairly common among patients with chronic brucellosis, but this was not borne out by a statistical survey. Of this group of 50, only 5 had pressures below 110/70. Only 1 was above 150/100, the remaining 44 individuals having pressures between these two extremes.

The patient listed in Table III as having coronary insufficiency did not show evidence of this at the time he was treated for chronic brucellosis, but four years later developed true effort angina and eventually succumbed to coronary occlusion. The electrocardiograms which were done on him at the time he was being treated for brucellosis were completely normal.

TABLE III
Associated Cardiac Conditions

	No.
Luetic aortic aneurysm	1
Auricular fibrillation, cause undetermined	1
Coronary insufficiency	1
Paroxysmal auricular tachycardia	1

TABLE IV
Associated Noncardiac Conditions

	No.
Secondary anemia-----	1
Hyperthyroidism -----	1
Menopause -----	2
Psychoneuroses not apparently secondary to brucellosis -----	5

ASSOCIATED NONCARDIAC CONDITIONS

Table IV is of considerable interest because there are included among these 9 patients a number of conditions which of themselves can produce symptoms referable to the heart.

The patient with hyperthyroidism had had a previous thyroidectomy, with subsequent lowering of her basal metabolism, but no real improvement in her cardiac symptoms.

A number of patients were moderately anemic, but only 1 had persistently low hemoglobin at a level which could be considered causative in the production of dyspnea.

Those patients listed with psychoneurotic or menopausal symptoms are of particular interest because of the close association of neurasthenia with chronic brucellosis. As has been repeatedly pointed out by the author and by many other writers, psychoneurotic manifestations are so common in chronic brucellosis as to be considered almost as part of the symptom complex of the disease. Whether this psychoneurotic tendency is directly caused by the brucella infection, whether it is secondary to the long, low-grade illness without satisfactory diagnosis or treatment, or whether it is, as some skeptics have affirmed in the past, the real cause of the patient's symptoms, remains undecided. These patients listed as psychoneurotic, not apparently secondary to brucellosis, were so classified because they gave histories of neurasthenic manifestations prior to the onset of their chronic brucellosis.

DIFFERENTIAL DIAGNOSIS

This brings us to the most important problem in chronic brucellosis, diagnosis; and it is not the purpose of this paper to discuss this in detail, as it has been adequately covered in many other publications.^{10, 11, 12, 13, 14, 15} A great many conditions have to be considered in the differential diagnosis of chronic brucellosis. In those patients

who presented themselves with principally cardiac complaints, organic heart disease had to be ruled out by all usual methods. In this connection it is important to emphasize the value of electrocardiograms performed after a measured amount of exercise in ruling out true coronary insufficiency. Master¹⁶ and others have shown the value of such procedures. In those patients who had some involvement of the locomotor system, the diagnosis of acute rheumatic fever sometimes caused concern. In my series, gastrointestinal symptoms have not been especially prominent, but when present they are often confusing and necessitate a thorough GI survey.

The most important and most baffling differential diagnosis was that between true neurocirculatory asthenia and chronic brucellosis. Because so many of these patients have psychoneurotic manifestations, and in view of the prominence which neurocirculatory asthenia assumes in war years, the physician is often hard put to decide whether brucellosis actually is causing the symptoms presented. In many cases nothing but a trial of therapy will give the correct answer. It should be emphasized that this trial of therapy should be over a sufficient period of time to have real value, and it is also wise in trying to diagnose brucellosis by this method to refrain from any other method of therapy which might cause confusion.

CONCLUSIONS

From this survey it would appear that the cardiac symptoms which are quite common in chronic brucellosis are secondary to the neurasthenia associated with the disease and are not caused by any organic change in cardiac anatomy or physiology. Presenting symptoms are often indistinguishable from those seen in idiopathic neurocirculatory asthenia. The origin of the neurasthenic symptoms in patients with chronic brucellosis remains undecided, but it is apparent that these patients are as liable to nonorganic cardiac complaints as those with neurasthenia from any other origin. Except for isolated cases of brucella endocarditis, there is no pathologic evidence that the brucella organism specifically affects the heart.

SUMMARY

In a series of 50 patients with chronic brucellosis, a significant number presented themselves with symptoms referable to the cardiovascular system.

Of this series, 27 (54 per cent) had either palpitation, dyspnea, precordial pain, or a combination of two or more of these symptoms.

The cardiac symptoms which the patient with chronic brucellosis presents are indistinguishable from those seen in neurocirculatory asthenia and do not depend on any organic cardiac lesion produced by the brucella organism.

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

Editorials

HEART WEEK

THE second annual appeal for funds will be conducted during Valentine Week. This project is of extreme importance to all the doctors in the state of Indiana.

Of the funds raised during this campaign 70 percent will remain in Indiana. They will be made available to our doctors for use in establishing research projects, fellowships, symposia and medical education in heart disease. The remaining 30 percent will go to the American Heart Association to aid in the overall national research program in heart disease.

The Indiana Heart Foundation has made a good start in establishing this program in Indiana and we feel that the doctors should continue to support this organization.

HEALTH UNITS FOR INDIANA

THE full-time local health department bill which is now before the General Assembly has been introduced at a time when public interest in health matters is at an all-time high.

Resolutions concerning medical care and public health which have been passed recently by such organizations as the Indiana Farm Bureau and the American Legion are evidence of widespread realization of the importance of good medical care and preventive medicine. The American Medical Association, at the recent interim session in St. Louis, through its House of Delegates, emphasized again its conviction that full-time health officers at the local and community level are necessary for the preservation of health.

The bill, as sponsored by the Indiana Advisory

Health Council, is designed to encourage and facilitate complete coverage of the state with full-time local health departments. It establishes a procedure and method, but does not provide an appropriation.

Funds, when made available, would be used primarily for three purposes:

1. Financial assistance to full-time multiple-county health departments which have been established in accordance with the law.
2. Establishment of training centers for the training of public health workers.
3. Financial aid to communities in the construction of housing facilities for established full-time health departments.

The establishment of training centers is one of the most important provisions of the bill. The American Public Health Association estimates that there is but one qualified person for every seven positions open in public health work. Through the agency of the training centers, Indiana would be able to train individuals, by affording them practical experience under supervision. Such training is designed to follow academic education in public health, in the same way that internships and residencies function in education for clinical practice.

The bill authorizes the allotment of state funds to local governmental health units on a proportionate basis. Local full-time health departments having a local appropriation of one-half mill per dollar of assessed valuation tax levy, or seventy-five cents per capita, would be entitled under the bill, when state funds are appropriated for this purpose, to an allotment of twenty-five cents per capita, or an amount sufficient to make one dollar per capita, whichever is greater.

The amount of funds needed for each of the first two years, should this bill pass, is approximately \$300,000 and when the entire state is covered by full-time local health units the maximum cost to the state would be \$1,225,000.

The bill, if enacted into law, will greatly facilitate the formation of health departments able to aid in solving problems of sanitation and preventive medicine at the local level. This is the level at which these problems may be dealt with most efficiently. Local health departments, with the aid and assistance of the State Board of Health when necessary, will be able to study and correct conditions inimical to good health, and will be able to afford the advantages of modern public health practice to the community.

INCREASED ENROLLMENT IN SCHOOL OF MEDICINE

ACTION by the State Budget Committee in making a special grant of \$116,500 to Indiana University School of Medicine, for the specific purpose of expanding its student enrollment, is to be hailed as a wise step in the interest of the public welfare.

In studying the problem of alleviating the shortage of doctors in Indiana, former Governor Ralph F. Gates requested a report from the University as to the possibility of increasing the number of medical students, without allowing any depreciation of the standards of education. Careful analysis of the teaching facilities has determined that such an expansion is feasible. Recommendations were made concerning the cost of remodeling which would be made necessary under the proposed enlargement. The employment of additional teaching staff, and the purchase of equipment and supplies were considered, and included in the financial estimate.

On the basis of the University's report the special grant of \$116,500 was made to the School of Medicine by the State Budget Committee.

Dean John D. VanNuys has announced that 21 additional students have been admitted to the first-year class, bringing that class to a total of 150. The special grant will be sufficient to allow the enrollment of a first-year class of similar size during next year, and will care for both of the enlarged classes through graduation.

It is important that the number of graduating doctors be increased, in order to meet the needs and desires of the public for increasing amounts and types of medical service. It is even more important that such increase be accomplished with the same high educational standards which have prevailed in the past.

Medical education is an expensive item. It is becoming more expensive. It is difficult, at a time when the demand for physicians is on the rise and when the costs of education are also rising, to maintain high standards on prewar budgets. It is to the credit of Dean VanNuys, the officials of Indiana University, and the officials of our state government, that the problem of increasing medical enrollment has been solved by the only means which will maintain good education—more money.

ANOTHER FEDERAL FAILURE

IT IS simply impossible for any single Federal agency to direct the multiple and diverse social and economic activities of a country as complex and huge as our own. This fact is being proved every day by the Hoover Commission now investigating the activities of the executive branch of the government.

In its report on the medical programs of the Federal government the commission has again revealed the overlapping and confusion, the extravagance and waste of such a comprehensive Federal program. More than 44 Federal agencies are now spending \$1,250,000,000 a year for different sorts of medical care. Much of this huge sum is unnecessary and goes down a rathole.

New projects have been initiated, says the report, "without any understanding of their ultimate cost, the lack of professional manpower to carry them out, or their adverse effect upon the hospital system of the country." Thousands of unqualified civilians are getting medical care from military facilities through the interpretation of an old law written 60 years ago. Huge new hospitals are being built within a few miles of other Federal hospitals that are almost empty. The supposedly unified Army and Navy are competing with each other to build hospitals when "there is no evidence that additional beds are needed."

It would take several years to reorganize this wasteful duplication of our already existing Federal medical programs. Yet the Truman administration is still intending to pile on top of this rickety mishmash a compulsory Federal medical insurance program which would add billions to the taxes paid by the people without adding any new doctors or hospitals to take care of them.

The attempts of the New Deal to solve everybody's problems in Washington is certainly proving the rightness of the founders of the American republic. They saw the necessity of local solutions to local problems. They also saw the dangers in centralizing control over social and economic activities which are so diversified that no single agency can properly administer them. They wrote into the Constitution that "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." They knew that no government of human beings was capable of playing God to the people of a nation as large and as diverse as America. The failure of our Federal health services as exposed by the Hoover Commission is just another proof of the sagacity of our founding fathers.

—*The Indianapolis Star*, Dec. 28, 1948.

Editorial Notes

HEALTH UNITS FOR THE NATION

The House of Delegates of the American Medical Association reaffirmed the stand of American medicine in regard to full-time health services, by adopting the following resolution, during its meeting on December 2, 1948, in St. Louis:

WHEREAS, No amount of medical care of persons already sick will substantially reduce the incidence of illness; and

WHEREAS, The traditional position of the American Medical Association has been one of firm support of public health services, in fact, this constitutes a major element of the ten-point national health program of the American Medical Association; and

WHEREAS, Large numbers of local areas and counties in the United States are not now and never have been covered by adequate sanitary and other public health services; and

WHEREAS, The Surgeon General of the U.S. Public Health Service has announced that one of his first major objectives is assistance in development of local health units throughout the nation to meet this fundamental need; and

WHEREAS, The medical profession has now an opportunity to exert constructive leadership in this matter, through the national, constituent state and component county medical societies; Therefore be it

Resolved, That the House of Delegates reaffirm its abiding interest in the necessity for the provision of full-time modern public health services at the local and community level, including sanitation and all the services usually considered essential for the preservation of the public health; and be it further

Resolved, That the U.S. Public Health Service be commended for, and encouraged in, its efforts for the further development of local health units for these purposes; and be it finally

Resolved, That the Board of Trustees be commended for its efforts in furthering full-time local health units and urged to continue actively all proper procedures to the end that local public health service shall become adequate throughout the nation.

Note on one phase of cancer control in Indiana (from *The Lake County Medical News*):

"CANCER CUPBOARDS"

"Cancer supply cupboards in the major hospitals of Lake county are growing in popularity by leaps and bounds.

"Supplies are available free to all Lake county physicians in the various hospitals, and many of them are taking advantage of the services in Hammond, Gary and East Chicago.

"Doctors can thank the Lake County Cancer Society for creating the cupboards. The LCMS auxiliary, through its branches, has arranged to maintain the project and members can be congratulated for their splendid work."



President's Page



COMMITTEE RESPONSIBILITY

IT IS the president's duty and privilege to appoint certain annual standing committees and such other special committees that he considers advisable.

If your name is listed in the appointees for 1949, it is not to be considered as an honorable mention, or just a friendly gesture. There is no "Palace Guard" in the Indiana State Medical Association. It means you have been entrusted with a job to be done in the greatest and most critical period in the one hundred years of scientific medicine in Indiana.

Your name was not picked at random from the membership roster. The members of the Council were consulted and advice was solicited from many medical leaders in every section of the state. The files of our state JOURNAL for the past five years were reviewed in order to determine the activities of previous committees and the active personnel in our county and district medical societies.

Many young physicians from every councilor district were asked to enlist in the official workshop of our organization and to prepare themselves to carry the banner of Indiana scientific medicine into the new century. These younger men have been placed on committees side by side with many of the older and distinguished wheel horses of our organization.

There is always efficiency and progress when the wisdom of experience and the initiative of youth work hand in hand.

Nearly three hundred letters were sent out to committee appointees requesting them to accept "a job to be done." Two hundred enthusiastic acceptances have been received as this February JOURNAL page goes to press, on January 8. Only three appointees have stated that they could not serve.

It has been the desire of your president to make his committee appointments geographically representative of the entire state and to decentralize the official family as much as possible without destroying the efficiency of our association.

If your name is not listed on the committee roster, it does not mean that there is nothing for you to do in the workshop of organized medicine. The real job is still back home, and each physician is chairman of his own Physician-Patient Relationship Committee.

There is a fertile field of endeavor for every committee appointed, and there should be no inactive or negative committee reports enrolled in the archives of our Centennial Year.

No committee chairman should call a meeting of his committee before he has studied and planned a program for consideration, and each member should consider in advance what he can contribute in constructive thought.

These are the fundamentals of committee organization, efficiency, and responsibility. Your president humbly asks that you do these things for the Indiana State Medical Association, and in memory and tribute to your beloved colleague,

NORMAN M. BEATTY,

a committeeman who never shirked his responsibility or came to a meeting unprepared. He was a great medical leader, whose thoughts were always constructive in the interest of mankind. His self-sacrificing devotion to the advancement of scientific medicine and the welfare of humanity will remain as an inspiration and a beacon light far into the new century of Indiana medicine.

Augustus B. Hauss

Medical Panorama *by the* ASSOCIATE EDITOR

THE NURSING SITUATION

"Nurses—nurses—we need nurses!" is the title of an editorial in *Philadelphia Medicine* for October 23, 1948. It states that steps are being taken to secure legislation to license practical nurses, so that two types of licensed nurses would become available:

"First, graduates of the three-year course we have today who are eligible for an R.N. and, with further study, a B.S. degree. Their status would be unchanged.

"Second, graduates of a one-year training course, who would become Licensed Practical Nurses to serve under Registered Nurses in hospitals and other institutions, and to provide practical and convalescent nursing in the home."

In the same issue is published the following report:

"State and Philadelphia Medical Societies Act"

"The question was on the agenda of the last meeting of the Committee on Public Health Legislation of the Medical Society of the State of Pennsylvania and a resolution was passed endorsing in principle the action taken this year by the House of Delegates of the A.M.A. in Chicago and recommending to the Board of Trustees of the State Medical Society that they endorse satisfactory legislation for enabling the proper training and licensing of Practical Nurses. A strong resolution advocating such legislation was passed by the House of Delegates at the State Centennial Meeting.

"The problem was also thoroughly discussed at the meeting of the Board of Directors of The Philadelphia County Medical Society held on Wednesday, Sept. 22, 1948. As a result, a resolution was passed endorsing legislation for the proper training and licensing of Practical Nurses and that letters be sent to the proper organizations notifying them of the Board's action.

"Practical Nurse Course in Philadelphia Schools"

"It is interesting to note that the Board of Education of the Philadelphia Public Schools have been foresighted enough to have propagated and established a thorough course of instruction in the Public School system for practical nursing under the coordination of Miss Katherine F. Grant.

"The first class was enrolled on October 15, 1947, and since that time sixty-five women have graduated. The course is a thorough one consisting of three months intensive class and didactic work and a nine months affiliation with an approved Hospital for practical training.

"Participating hospitals have been Hahnemann, Mt. Sinai, Philadelphia General, St. Luke's and Children's, Temple and the Home for Incurables.

"Requirements for admission are: 1. Philadelphia residence. 2. Ages between 18 and 50 years. 3. Good health. 4. American citizenship or first papers. 5. One year of high school education. 6. Good character references. 7. A genuine liking for people. 8. An interest in caring for the sick.

"Objectives of the course are: 1. Ability to care for —(a) convalescent patients, (b) chronic invalids, (c) the aged, (d) convalescent maternity patients and their babies, (e) similarly, acutely ill patients not needing highly technical treatment.

"2. Preparations to serve as nursing assistants in Hospitals.

"3. Training for housekeeping as well as nursing duties in the home.

"4. Understanding of relationships to the physician, registered nurse, the patient, the family and the community.

"5. Understanding of the care and normal development of well children."

The above report is not only of interest in showing the similarity of the nursing problem in Pennsylvania to that in Indiana, but it also contains some very practical suggestions as to concrete action which may be of use in our own state. We presume the Licensed Practical Nurse would be "L.P.N." in contradistinction to "R.N." This would give such a licensee a degree of pride in her work, which would soon come to bear the same relation to the field of nursing that that of the G.P. bears to the field of medicine. The "R.N.'s" would be the specialists.

DR. CLAUDE S. BLACK

PRESIDENT-ELECT

DR. CLAUDE S. BLACK, of Warren, was elected to the office of president-elect of the Indiana State Medical Association on October 28, 1948. During 1949 he will be concerned with the numerous

duties of this office, and in 1950 will succeed to the office of president.

Doctor Black is a native-born Hoosier, having been born, reared and educated in Huntington County. After studying at Indiana University, he attended Indiana Medical College, and was graduated with the degree of Doctor of Medicine in 1905.

Since 1905, with the

exception of time spent in postgraduate study in New York City, and with time off for military service in World War I, Doctor Black has been engaged continuously in the general practice of medicine in Warren.

His selection to the highest office in the state association culminates many years of praiseworthy service to the medical societies of which he is a member. He is past president of the Huntington County Medical Society and of the Eleventh District Medical Society. He has just completed 15 years of service as councilor for the Eleventh District.

Doctor Black has evinced his interest in the scientific activities of the state association by holding office as secretary of the Section on Medicine, and as chairman of the Section on General Practice. He has also been a member of the Advisory Board of the State Welfare Committee, and a director of the Mutual Medical Insurance Company.



Claude S. Black, M.D.

PROGRESS OF THE INDIANA HEART FOUNDATION

DURING the past year several articles have been written and information has been sent to the doctors over the state concerning the Indiana Heart Foundation. This organization was set up at the suggestion of the American Heart Association to help in the drive to promote a better understanding of heart disease.

From February 7 to 28 a fund-raising campaign will be conducted. Of the funds collected 70 percent will remain for the use of the Indiana Heart Foundation in its program of education and research in Indiana. Thirty percent will go to the American Heart Association to aid in its overall program.

From the funds that were collected in 1948 a Fellowship in Cardiology has been established at the Indianapolis General Hospital and a full-time medical social worker has been provided for the Cardiac Clinic at the Indianapolis General Hospital. Much educational material, in the form of pamphlets, has been distributed to doctors and laymen over the state. A request has gone out to each county medical society for suggestions as to how the Indiana Heart Foundation can materially assist the doctors in their localities. A Penicillin Fund

for the treatment of subacute bacterial endocarditis is being established, patterned after that of the New England Heart Association.

To continue this work and to expand the program further to meet the needs of the doctors over the state more funds will be needed. The Indiana Heart Foundation needs every doctor in Indiana as a member. The Indiana State Medical Association, through its Heart Committee and the liaison member of the Foundation's Board of Trustees, formulates the policies of the Foundation.

Each Councilor was asked to appoint a doctor in his councilor district, who is interested in heart disease, to act as liaison between his area and the Heart Foundation. This doctor's job is to coordinate the facilities of the Indiana Heart Foundation with the needs of his councilor district.

The county medical society presidents have been asked to appoint a physician chairman to work with the lay chairman in his county for the coming campaign.

It is desired that the doctors will respond by joining the Indiana Heart Foundation and assist in this campaign.

SOCIALIZED MEDICINE IN GERMANY*

HERMAN B WELLS†

BLOOMINGTON

I SHOULD like to say a few words about socialized medicine in Germany. Health insurance has been common in Germany for many decades. During the last few years, however, it has expanded considerably until today in Berlin and in the Soviet Zone more than 90 percent of all individuals are covered by compulsory health insurance.

In the Western Zones compulsory health insurance is essentially administered and organized as it was during the Weimar Republic. In the United States Zone compulsory health insurance covers all employed persons, independent teachers, artists, nurses and homeworkers earning less than a certain amount of money per year. (Before currency reform 3,600RM.) The average contribution, deducted from wage or salary, is between 5 and 6 percent of the wage or salary; one-third of the contribution is paid by the employer and two-thirds by the employee. It is reported that in the Soviet Zone and Berlin, employer and employee each pay 10 percent of the wage or salary for compulsory insurance.

The patient obtains a "sickness certificate" from a governmental agency and is then entitled to free medical care from any doctor who has been licensed by the state insurance organization. The physician is paid a fixed amount according to the disease of the patient. The number of times that the physician must see the patient to effect a cure does not influence the fee.

In the Western Zones a doctor need not join the state organization if he does not wish; in Berlin and the Soviet Zone no doctor is permitted to refuse a patient, and all must participate in panel practice.

In practice the widespread institution of compulsory social insurance has been a powerful factor in the general lowering of standards of the medical profession. Some doctors go so far as to say that the panel practice has caused the moral and ethical standards to fall further than the purely professional standards. The fees received from panel practice are so low that physicians are forced to seek devious ways and means to increase their income. This is done by treating insured patients superficially in order to handle as many as possible. In other cases the patient is

made to understand that he will be given better care if he pays out of his own pocket an additional fee. Separate waiting rooms for "private" and panel practice are common; dentists use different materials for different "types" of patients. For many medicine is no longer a profession, but a business based on cold calculation and the principles of mass production. Gone is the interest in performing thorough, scientific, honest work.

Not all doctors and dentists, however, have fallen into the morass of cheap commercialism. Many idealistic men, the true physicians, continue to apply the highest standards to all their patients, regardless of whether or not they are "private" patients. But the fact remains that socialized medicine, in the way it is organized and practiced in Germany, has worked by and large to the detriment of the patient, the doctor, and to medical science.

In this connection it is important to notice that the private health insurance agencies which were well developed in Germany, are gradually losing ground. This is, of course, especially true in the Soviet Zone. Everywhere the state-controlled *Krankenkasse* increases its power and influence. Its enormous receipts are controlled by the government and, especially in the Soviet Zone where the SED controls the funds of the *Krankenkasse*, the compulsory, state-operated health insurance system is a powerful weapon in the political struggle. The Chamber of Physicians, corresponding to our AMA, is a feeble match for the colossal state organization.

I have attempted to picture for you the conditions affecting German medical and dental education. It is not a bright picture. Dark as it is, there are, nevertheless, foundations upon which medicine and dentistry in this devastated land can be given new life if the necessary assistance is forthcoming.

The German universities and research institutions have a small nucleus of progressive men who wish to advance the frontiers of science in a peaceful, democratic atmosphere. But the morass into which German academic and professional life has sunk is so deep that the Germans cannot be expected to rise again by themselves. Twelve years of Nazi tyranny, war, defeat, and social and economic chaos have made out of German medical education and research an outmoded and sporadic groping for facts. Political domination of science and an enforced, as well as a partly voluntary, isolation of German scientists from the rest of

* Excerpt from an address on "Medical and Dental Education in Germany," presented at the Indiana University School of Medicine, in Indianapolis, on November 5, 1948.

† President, Indiana University.

the world have been responsible for the lag of German medical education and science behind that of other more progressive nations. Yet the health of the German people is entrusted to the German medical profession, and the health of our Western European allies is in danger if Germany should become Central Europe's breeding ground of infection and disease.

Once upon a time the German medical schools provided the scientific impulse for a world-wide advance of medicine and the healing arts. We were

the beneficiaries of their skill and their generous welcome to foreign students. The wheel of fortune has turned, and our medical and dental schools occupy a place of pre-eminence. We cannot escape our responsibility for leadership and training in this field any more than we can escape the responsibility of leadership in the political field.

It has been said that this is the American century. It is certainly the century of the American university. Let us hope that we shall not fail the unborn generations of the world.

THE HISTORY OF MEDICAL JURISPRUDENCE IN THE STATE OF INDIANA DURING THE NINETEENTH CENTURY*

RAYMOND O. CLUTTER†

INDIANAPOLIS

MEDICAL Jurisprudence, Legal Medicine, or Forensic Medicine, as it is variously termed, is that science which applies the principles and practice of the different branches of medicine to the elucidation of doubtful questions in courts of justice. Some authors also use the term to include medical police. I shall employ the term at this time in its broader meaning.

Indications of this science can be found as early as the institution of civil society. Thus, in the early Jewish law the distinction was established between mortal wounds and those not mortal. According to Plutarch, the Egyptians ordained that no pregnant woman should suffer afflictive punishment, and the Romans, even as early as the period of Numa, established many of their laws on the authority of ancient physicians and philosophers. *Propter auctoritatem doctissimi Hippocratis* (because of the judgment of the most learned Hippocrates) is a phrase frequently used in decisions; and the Emperor Adrian was influenced in extending the term of legitimacy from ten to eleven months by the prevailing sentiments of the physiologists of that day.

The Roman historians mentioned some striking medico-legal facts. We are told that the bloody remains of Julius Caesar, when exposed to public view, were examined by one Antistius, who stated that out of twenty-three wounds which Caesar had received but one was mortal, and that had penetrated the thorax, between the first and second ribs. The body of Germanicus was also inspected,

and, according to the indications conformable to the superstitions of the age, it was decided that he had been poisoned.

The code of Justinian contains many provisions appertaining to this science. Some of these provisions are found in the laws of almost every civilized country today.

The provisions found in these ancient laws, however, are to be considered as merely the first glimmerings of knowledge on this subject—and knowledge, too, founded on the imperfect diagnostics which medicine afforded at that early period.

Physicians were never examined on trial until after the middle ages when the Emperor Charles V of Germany by public enactment prescribed it necessary, thereby recognizing its value and importance. In the celebrated criminal code, the "Constitution Criminalis Carolina" or the Caroline Code, which was framed by him at Ratisbon, in 1532, it was ordained that the opinion of medical men should be formally taken in every case where death had been occasioned by violent means. This code very naturally awakened the attention of the medical profession and summoned numerous writers from its ranks. This might be called the first regular commencement and origin of legal medicine. Its utility was immediately recognized. The kings of France soon became aware of the value of medical jurisprudence, and in 1556 Henry II promulgated a law which prescribed death for the female who shall conceal her pregnancy and destroy her offspring.

Henry IV presented letters patent to his first physician in 1606, which gave him the privilege of

* Presented at a meeting of the Indiana Association of the History of Medicine.

† Member of the Indiana Bar.

nominating two surgeons in every city and important town who should examine all wounded or murdered persons and make reports thereon; and in 1667 Louis XIV declared that no report should be valid unless it had received the sanction of one of these surgeons. At a later period (1692) physicians were by law associated with surgeons in these examinations.¹

During the Eighteenth Century medical jurisprudence was developed to a great extent in the English Common Law. It became common procedure for physicians to testify as expert witnesses in cases where medical knowledge was needed. Thus, by the time a government was set up for the Northwest Territory, the basic concepts of medical jurisprudence were already firmly established.

There were few regulations in regard to medicine in the Northwest Territory before Indiana became a state. In fact, the first reference in the laws of the Northwest Territory appeared in the "Act Reorganizing the Courts of Justice," approved December 31, 1813, which contained the provision that "no practicing physician shall, in the future, be eligible to act as a judge of the superior or inferior courts of record within this territory." A five hundred dollar penalty was imposed for a violation of this provision—intended perhaps to prevent any conflict between medical and court duties.² This provision was repealed September 10, 1814.³ On December 26, 1815, an Act was passed which required the sheriff of any county, when satisfactory evidence of the insanity of any individual was presented, to call a jury of twelve men, one of which must be a physician, to determine if such person was actually insane. If the jury found that the person was insane, the court was directed to appoint three guardians to take care of the person and his property.⁴

When Indiana became a state the General Assembly wasted little time in attempting to regulate the practice of medicine. In December, 1816, an Act to regulate the practice of physic and surgery was enacted by the General Assembly and approved by the Governor. This law set up medical districts corresponding to the judicial districts of the state. In each district a board of medical censors was to be organized. Authority was conferred upon them to examine and license to practice any applicant who they might consider properly qualified. They were also given the authority to expel any licensed physician who might be guilty of intemperance or immorality. Any person who was not licensed by this board could not have the benefit of the law for collecting his charge for professional services, and the law also set up

a schedule of fees for medical services.⁵ In 1818 any person who was already practicing in the state in 1816 was exempted from this provision. The next year the State Medical Society was incorporated and granted power to license physicians. Any person who practiced without a license from the State Society was subject to a fine of from ten to twenty dollars for the first offense and double thereafter. The money so collected was to go to the State Society for the promotion of medical science. By amendment in 1823 it was switched to the county seminaries.

Just why the setup under this law was unsatisfactory is not clear, but at any rate in 1825 another law provided all over again for the organization of a Medical Society in the State of Indiana. It granted a charter to a Central State Society, provided for local societies corresponding to the judicial districts, enforced the regulations already made, and provided for the continuation of the societies by fixed rules of representation. From the words of the law which read, "The society when thus formed," it would appear that no society had been formed under the Law of 1818. This time the Society was given the additional power to establish "a uniform system of the course and time of medical study" to qualify for licenses.⁶

The effectiveness of the 1825 Law may be judged in the words of the Law of 1830 which stated that, "Owing to the defects of the law regulating the practice of physic in the State, the medical societies, which now exist, have never been legally organized, and the provisions of the Act are such as to not induce a large portion of qualified physicians to become members of any medical society, or sufficiently to guard against licensing unqualified men to practice medicine. . . ."⁷

The Law of 1830 attempted to remedy those evils by legalizing the existing societies when they should file their names and those of their officers with the proper county auditors. They were to have all the powers granted under the Law of 1825 and it was provided that after one year no person, not regularly licensed in Indiana, could recover anything by law for medical services. There was a big exception, however, which practically nullified this Act for it excepted females practicing midwifery, and allowed apothecaries or others not professing to prescribe or practice medicine to sell medicine and recover payment therefor. Thus, farmers, blacksmiths and others frequently tried their hands in practicing medicine under the exceptions.⁸

1. See introduction to Beck's Medical Jurisprudence.

2. Ewbank and Riker, *Ind. Hist. Collections*. Vol. XX, *Laws of Ind. Territory 1809-1816*, p. 65.

3. Ewbank and Riker, *Supra*, p. 562.

4. Ewbank and Riker, *Supra*, p. 650.

5. *Indiana Medicine in Retrospect*, p. 9, reprinted from *J. Ind. St. Med. Assn.*, Vol. 29, Nos. 2 to 12, inclusive, 1936.

6. Kemper, *Medical History of Indiana*, (1911), p. 167; Pickard and Buley, *The Midwest Pioneer*, (1945), p. 256.

7. *Laws of the State of Indiana* (1830), Ch. XLIX, 91-3.

8. Pickard and Buley, *Supra*, pp. 256, 257.

Perhaps the failure of these laws can be attributed to the fact that they attempted too strict regulation for those primitive days. Physicians of a high grade could not always be secured, so unskilled midwives, medicine men, and quacks were suffered, through sympathy, to attend our early inhabitants. These laws did not stay on the statute books long. A report of the Evansville Medical Society submitted at the session of the State Society held at New Albany, May 19, 1852, contained the following words, "Since 1830 these laws have all been repealed and none others enacted in their place."⁹

The repeal of these medical laws left our state at the mercy of anyone who chose to assume the name of "doctor" for the next 55 years. In 1833 the legislature of Indiana incorporated The Christian College, located at New Albany and later known by the names of University of New Albany and University of Indiana. (This institution has no connection whatever with the present Indiana University.) The institution became the first medical diploma mill of record in the United States. The first president was John Cook Bennett, a man who signed his name as Dr. Bennett before the university was organized and soon thereafter signed it John Cook Bennett, M.D., by reason of having awarded himself a degree. Medical diplomas of this university have been found attesting to the fact that the degree of Doctor of Medicine was issued forty days after the charter was granted. It appears that Dr. Bennett peddled his diplomas throughout the United States, and the institute at New Albany and its diplomas were called fraudulent as early as December, 1833.¹⁰

Further misuse of the word "doctor" is provided by an episode that happened in Connersville, Indiana, in the mid-thirties. According to the records, Joseph S. Burr nailed up to the weatherboarding of the hotel in Connersville an enormous swamp lily root, almost as large as a man, with head, eyes, nose, ears, and mouth nicely carved, arms and legs with feet stuck on, and just above the sign on a board, marked with chalk, "Joseph S. Burr, Root Doctor; No calomel." Apparently, hundreds came from all parts of the country to see the doctor and the big root. They must have consulted him, too, for the regular doctors brought suit against him, people took sides, a lawsuit and trial followed and the root doctor ran away.

Although Joseph S. Burr ran away, one of his pupils, Thomas T. Chinn, continued in his steps. Mr. Chinn, barely able to write his name, was constable three weeks before attempting to practice medicine. He became "Dr. Chinn, Root Doctor and No Calomel." In one of his own accounts he stated, "I lost only nine fine patients last week,

one of them an old lady that I wanted to cure very bad, but she died in spite of all I could do. I tried every root I could find but she still grew worse, and there being nobody here to detect my practice, like the other regular doctors, I concluded to try calamus and dug up a root about nine inches long and made a tea of it. She drank it with some difficulty, turned over in the bed and died. Still I don't think it was the calamus that killed her, as all the calamus doctors are giving it in heavier doses than I did."¹¹

While the legitimate physicians were doing their best to stop the practice of quackery in the state, the quacks were at the same time doing their best to discredit the legitimate doctors. About 1830 a little, pock-marked Irish doctor, who had been but a few years from the Emerald Isle, with a rich brogue upon his tongue, having a good spice of the blarney, and a very laudable ambition to become a competitor of Dr. H. G. Sexton in Rushville, instituted a malpractice suit against Dr. Sexton for the purpose of discrediting him. The malpractice alleged was that Dr. Sexton had caused the hands of one of his patients to become entirely stiff. The Irish doctor, who stood upon the witness stand as the main and only witness for the plaintiff, clearly testified to the malpractice of Dr. Sexton and triumphantly pointed to the stiff fingers. The Irishman's true character, however, was discovered on cross-examination when he refused to answer pertinent questions concerning the disease in question. It became evident that the Irishman had little medical knowledge and was finally rescued when the attorney for the plaintiff requested the court to find for the defendant.¹²

Finally, in 1885 the legislature again enacted a law to regulate medicine, surgery and obstetrics. The Act provided a system of registration wherein the clerk of the Circuit Court of each county issued licenses to physicians practicing in the county. The law specified that the clerks were to issue licenses to graduates of reputable medical colleges, those who had attended one term of medical lectures and had practiced three years in the county, and to any physician who had been engaged in practice for ten years. Another provision stipulated that after a specified date only those who were graduates of reputable medical colleges should be permitted to begin practice within the border of the state.¹³

The perfect law had not yet been enacted, but, unlike the early laws, this one was followed by more rigid and better laws. It was imperfect in that it left the moral standing of the applicant and the reputability of the college to the judgment of the clerk of the court from which there was no appeal. There was no real standard by which to measure the requirements, and the decisions were characterized by a remarkable degree of elasticity.

9. Kemper, *Supra*, p. 167.

10. Waite, *The First Medical Diploma Mill in the United States*, reprinted from *Bull. History Med.* Vol. XX, No. 4, November, 1946.

11. Pickard and Buley, *Supra*, pp. 36-37.

12. Smith, *Early Indiana Trials and Sketches*, pp. 39-40.

13. *Laws of Indiana*, 1885, p. 197.

Soon after the law was enacted, its constitutionality was challenged but the Supreme Court of Indiana upheld the law as being within the police power of the state. But the court warned that it was not within the power of the legislature to discriminate against any particular school of medicine, so long as the practitioner had the required learning and skill in the school of medicine in which he professed to practice.¹⁴ The court also held that anyone who undertook to practice medicine without a license could not recover compensation for his services.¹⁵

In 1888 there arose a controversy under this law which required the court to decide whether certain acts constituted the practice of medicine. A Milton C. Benham, of Richmond, Indiana, issued circulars signed "Dr. M. C. Benham" in which he claimed that his "treatment" of his "patients" would effect "a complete cure of the opium habit." When prosecuted for practicing medicine without a license he raised the defense that the opium habit was a vice and not a disease and therefore he was not practicing medicine. The courts took a realistic view of the matter and fined him \$10.00.¹⁶

In 1897 the legislature replaced the Act of 1885 with a new law but provided that all physicians who had registered under the Act of 1885 and had been in continuous practice in the state since that date should be permitted to register under the new law. The Law of 1897 for the first time created a Board of Medical Registration and Examination to which all applications for registration were to be made. It was the duty of the Board to issue permits in the way of certificates, and upon presentation of these certificates to the clerk of the county in which the applicant lived and proposed to practice, a license was to be issued by the clerk. To be entitled to a certificate an applicant had to be a graduate of a reputable medical college but the standard of a reputable college was determined by the Board.¹⁷

Soon after the law was enacted it was tested and upheld, but the language used by the court in the case showed that there was still some doubt as to the wisdom of a law to regulate medicine. The court said it was not passing upon the question whether the law was a wise one since it might be that "as men are free to choose those who shall minister to the needs of the soul, so also should they be free to choose those who shall minister to the ills of the body. It may be that such laws repress independent investigation, and so retard the progress of medical knowledge."¹⁸ Nevertheless, the court felt duty-bound to enforce the enactment of the legislature and upheld the law.

During the Nineteenth Century medical jurisprudence was being developed in other phases.

With so many people assuming the name "doctor" in the state, it was only natural that the courts would have to deal with the subject of negligence and malpractice. In 1860 the court laid down the rule that a physician is liable for damages arising from either want of skill or the application of less skill than the occasion requires, but it failed to establish a standard of skill to be applied.¹⁹ This omission was remedied in 1877 when the court stated that physicians and surgeons are bound to possess and exercise at least the average degree of skill possessed and exercised by the members of their profession generally. But the court limited recovery to cases where the injured is not also negligent.²⁰

During the early history of Indiana the physician, as now, had difficulty collecting his fees. It was therefore necessary for the court to determine whether a physician had any right to compensation. This question was litigated in 1833 when a physician by the name of McNamee, in Knox County, sued one Judah for fees in connection with services. As a defense, Judah stated that under the Common Law of England no action will lie for fees of a physician and we have adopted the Common Law of England. The court discussed at length the general principle in England that the fees of a physician are honorable and not demandable of right, since to assert that right would place physicians in society on a footing with common men. The Supreme Court of Indiana soon disposed of the English precedent by stating that although we have adopted the Common Law of England, it is a qualified adoption, and this principle is inconsistent with the spirit and genius of all our institutions which are based upon the great and broad principle of liberty and equality and know nothing about nobles and ignobles, honorables and common men. Since we have no privileged orders known to the law, either as to suing or being sued, the court allowed the physician to collect his money.²¹

This case regarding compensation was followed by others which established that a physician could receive what his "services are reasonably worth."²² Where a physician has previously made charges for similar services, such charge can be used as evidence to establish the reasonableness for a charge for similar services.²³

No discussion of medical jurisprudence would be complete without some mention of the physician as an expert witness, for that is the heart of the whole subject. The right of the physician to testify as an expert has been recognized so long, and was so firmly established in the English Common Law by the time Indiana became a state that it was accepted in Indiana with little controversy. The first time the Supreme Court of

14. *Eastman v. State*, 109 Ind. 278, 10 N. E. 97 (1887).

15. *Orr v. Meek*, 111 Ind. 40, 11 N. E. 787 (1887).

16. *Benham v. State*, 116 Ind. 112, 18 N. E. 454 (1888).

17. *Laws of Indiana*, 1897, p. 255.

18. *State v. Webster*, 150 Ind. 607, 50 N. E. 750 (1898).

19. *Long v. Morrison*, 14 Ind. 595 (1860).

20. *Gramm v. Doener*, 56 Ind. 497 (1877).

21. *Judah v. McNamee*, 3 Blackford 269 (1833).

22. *Peck v. Martin*, 17 Ind. 115 (1861).

23. *Sidner v. Petter*, 19 Ind. 310 (1862).

Indiana mentioned the right of a physician to testify as an expert witness was in 1839 in an insanity case where the court stated that only men of medical skill may be asked for opinions where there are certain appearances or symptoms of insanity.²⁴ In 1871 the Supreme Court ruled that physicians could testify on the subject of insanity whether the physician be a specialist in that field or not. The court said "It is the custom of our American Judges, throughout the country, to accept of all educated and practicing physicians as experts, whether they have given special attention to the disease of insanity or not."²⁵ At later dates

the Supreme Court ruled favorably upon the right of a physician to testify as to the effects of injuries,²⁶ and wounds.²⁷ The scarcity of cases during the Nineteenth Century concerning the right of physicians to testify as expert witnesses is undoubtedly attributed to the fact that his right was never questioned.

By the end of the Nineteenth Century medical practice was being regulated and the basic principles of medical jurisprudence were recognized in Indiana. The physician was making an important contribution to the administration of justice which he has continued to do to the present day.

24. Doe, on the Demise of Sutton v. Reagon, 5 Blackford 27 (1839).

25. Davis v. State, 35 Ind. 496 (1871).

26. The Noblesville and Eagletown Gravel Road Company v. Guase, 76 Ind. 142 (1881).

27. Doolittle v. State, 93 Ind. 272 (1883).

ANOTHER SOCIALISTIC FAILURE

As in England, the evidence accumulated elsewhere proves that socialized medicine falls far short of the utopian promises of Communists and Socialists. New Zealand has had socialized medicine since 1939, and nine years certainly is long enough to have established it, but today it is charged with being a monstrous failure. British Laborites contend their medical scheme has not been in effect long enough to have a fair test, but New Zealand certainly has given it a fair test.

Dr. A. Lexington Jones of Christchurch, New Zealand, predicted before an American medical assembly not long ago that the dominion's experiment with free-lunch-counter medicine was doomed to complete collapse. As in Britain, the human factor has made the thing unworkable. It has become an unholy hodgepodge of mass hypochondria, bureaucratic bungling and deterioration of medical standards.

"The patient is free to visit as many doctors as he wishes per day, per week or per year 'without cost' to himself . . ." Dr. Jones told his audience. "He may indulge in this peregrinating pastime among the doctors until his heart is content or until he finally interviews a doctor who will do as he bids, give him the medicine he desires and put him in the institution of his choice. . . ."

In 1945 more than 205,000 New Zealanders entered hospitals. Based on this figure, America will have to provide accommodation for a permanent hospital population of 17,000,000 if we ever go over to socialized medicine!

President Truman says he intends to seek a program of compulsory health insurance. This in itself is not the unhappy ultimate of socialized medicine. But it is a long step in that direction. If Mr. Truman gets his proposal through Congress and a "cradle-to-the-grave" philosophy prevails in this country, we undoubtedly will follow Great Britain and New Zealand into the wilderness.

Dr. Jones recalled that Lenin called socialized medicine "the keystone to the arch of the Socialist state." Undoubtedly the crafty Lenin perceived that socialized medicine could not be effective outside a stern totalitarian economy and therefore looked on it as a highly effective means to an end. Let us take heed!

The Indianapolis Star

AN ITEM IN THE NEWS

A short time ago an item appeared in the news which, while it didn't make banner heads, is an example of the kind of arduous progress that serves us all.

Last year, the item said, the death rate from tuberculosis dropped to a new low throughout the nation. For the first time in our history, the number of fatalities from this cause was under 50,000.

That wasn't the result of chance. It was, instead, the result of decades of hard and often unrewarding work by doctors and other scientists. A long list of factors had a part in the achievement—better preventive medicine, infinitely improved methods of treatment for the afflicted, a generally higher standard of living, and so on.

Every major advance in medicine, save for rare instances where some revolutionary drug is discovered, is made much in this way. And the United States, with its system of medicine, unhampered by bureaucratic domination, has been a leader in conquering disease—a fact which has been proven in survey after survey. By contrast, medicine has generally been backward in the nations where it is controlled by the state—the standards of treatment have gone down while the cost, as in the case of all governmental activity, has gone up.

We in the United States are leading longer, healthier lives. Diseases which were almost sure killers not so many years ago now offer little danger. A system of voluntary prepaid medical care has been built up which brings the cost of treatment and hospitalization within the easy reach of the majority of people. These are achievements of free medicine which must not be forgotten.

Journal-Courier, Lafayette

WEST COAST FIRM EMPLOYED TO DIRECT A.M.A. CAMPAIGN

THE American Medical Association has announced that Clem Whitaker and Leone Baxter, managers of a public relations firm which has its home offices in San Francisco, have been retained as public relations counsel to direct a broad program of public education.

The firm of Whitaker & Baxter will campaign to promote voluntary health insurance and alert the American people to the danger of a politically-controlled compulsory health system.

A 10-member Planning Committee approved employment of the San Francisco firm shortly after the House of Delegates of the A.M.A. voted at the St. Louis meeting to assess each of the 140,000 A.M.A. members \$25 each for a nationwide plan of education on the progress and health program of American medicine.

For the first time in its 100-year history, the House voted such an assessment to finance a campaign which will stress the importance of the conservation of health and the advantages of the American system in securing a wide distribution of a high quality of medical care.

In making the assessment, which will create a fund estimated at between two and three million dollars, the House reaffirmed its stand against "socialized" medicine and against any form of compulsory sickness insurance as proposed in the recent distorted health report by Federal Security Administrator Oscar Ewing.

In a statement which followed action by the House, the Board of Trustees pointed out that the report on "The Nation's Health" by Mr. Ewing was a complete departure from the conclusions of the 800 interested leaders in the field of health, agriculture, industry and welfare who attended the National Health Assembly called by Mr. Ewing in Washington.

Since the St. Louis meeting, the A.M.A. Board of Trustees adopted a recommendation of its executive committee to establish the 10-doctor Planning Committee, which will govern the overall policies of the campaign.

This Planning Committee will consist of four members of the Board of Trustees and officers, and three from the House of Delegates, with the President, the Chairman of the Board and the Secretary and General Manager serving as ex officio members, all of whom will have voting powers. As a result, the Planning Committee will consist of:

Drs. Edwin S. Hamilton, Kankakee, Ill.; Gunnar

Gundersen, La Crosse, Wis.; Walter B. Martin, Norfolk, Va.; and Louis H. Bauer, Hempstead, N.Y., all members of the Board of Trustees; Drs. William Bates, Philadelphia; John W. Cline, San Francisco, and R. B. Robins, Camden, Arkansas, all members of the House of Delegates; President R. L. Sensenich, South Bend, Ind.; Chairman of the Board of Trustees Elmer L. Henderson, Louisville, Ky., and George F. Lull, Chicago, secretary-general manager of the A.M.A.

A great deal of organizational work has already been done by this group. At a meeting in A.M.A. headquarters, Chicago, recently, the executive committee of the Planning Board authorized employment of the Whitaker-Baxter firm.

The campaign will be directed from a Chicago and Washington office, working closely with A.M.A. headquarters and with the association's public relations department.

Mr. Whitaker and Miss Baxter directed the campaign of the California Medical Association which defeated the program of compulsory health insurance proposed in that state by Governor Earl Warren.

Four years ago only about 2,500,000 California citizens were enrolled in voluntary health insurance plans. Today, as a result of the state association's continuing educational campaign, there are more than 100 voluntary health insurance systems operating in California, with more than 5,000,000 insured members—a million more than Governor Warren promised to care for under his compulsory program.

The Whitaker firm, which represents several major industries on the west coast, has been engaged for the past 15 years in the professional direction of campaigns on political and economic issues.

After a preliminary study, Mr. Whitaker announced that the A.M.A. public education campaign would be built around the following three objectives:

1. To awaken the people to the danger of a politically controlled compulsory health insurance system.
2. To acquaint the people with the superior advantages of American medicine over the government-dominated medical systems of other countries.
3. To stimulate the growth of voluntary health insurance systems and prepaid medical care plans to take the economic shock out of illness and increase the availability of medical care to the American people.

ARMY CIVILIAN INTERN AND RESIDENCY PROGRAM

THE opportunity to participate in the Army Medical Department's Civilian Residency Program will be given to approximately 300 selected physicians beginning December 15, 1948, according to an announcement from Major General Raymond W. Bliss, The Surgeon General.

The program permits the training of these physicians under the sponsorship of the Army Medical Department.

Under the Civilian Residency Program, civilian physicians who have obtained a residency acceptable to the Specialty Board at an institution approved by the American Medical Association, may apply for a commission in the Regular Army and participate in this program if they are selected by The Surgeon General upon review of their qualifications.

Physicians who are professionally and physically qualified for, and accept a Regular Army commission, will be assigned to the civilian hospital in which they are a resident and will draw full pay and allowances of the grade in which they are commissioned. They will be commissioned in grades of 1st lieutenant and captain.

The program has been established for the purpose of providing specialty training to physicians who are sincerely interested in pursuing a career in Army Medicine. Physicians participating in this program will be required to serve two years of active duty for each year of formal training received under the auspices of the Army Medical Department. Continuance in such civilian residency training is contingent upon selection by their hospital for the higher level of residency training.

It is the purpose of the Army Medical Department that participants will complete the minimum formal resident training in their selected specialty and then be assigned to an Army installation where they can obtain practice requirements for board certification.

Application should be submitted by March 15, 1949, to receive initial consideration. Applicants will be advised of selection or non-selection shortly thereafter. The Civilian Residency program for the fiscal year 1950 will begin July 1, 1949.

The Civilian Residency Program has been presented to the Council on Medical Education and Hospitals of the American Medical Association and to the Association of American Medical Colleges. Both bodies have officially recognized the value of the program in its entirety.

Physicians wishing to participate in the Civilian Residency Program can procure the necessary applications from The Surgeon General, Attention: Chief, Procurement Branch, Personnel Division, Washington, D. C.

WHY GIRLS BECOME NURSES

Doctors play a major role in helping girls decide to become nurses, according to a survey of students in last fall's beginning classes in nurses training. Made by the Indiana State Nurses' Association, the study covered 730 girls enrolled in accredited schools of nursing in Indiana.

Of this number, 217 said they have been influenced principally by a doctor. Relatives, graduate and student nurses, teachers and ministers also ranked high. Some 319 listed visits to hospitals as a contributing factor.

Books, radio and movies also were given some credit. Under "other influences" most of the girls said, "I've always wanted to be a nurse." Some helped care for invalid parents or ill brothers and sisters, took home nursing while in the Girl Scouts. Others saw nurses on duty in the war when they were WAVES or WACS and decided then to take training. Some said, "I know there is a great need for nurses," others, "I've always had great admiration for doctors and nurses." Some had been given a doctor's or nurse's kit when a child and liked playing nurse so much they never forgot it.

Curiosity about the causes of disease, an interest in science, desire to have a career she could always use, wish to serve others, to enter the foreign mission field, all were motivating factors. Some wrote themes on nursing in high school and learned so much about it they decided to enter training.

"My life was saved in a hospital when I was eight years old," one girl said. "I've had four operations," "Nurses were kind to my mother," "My mother is a nurse and I want to be like her," and "The profession of nursing is always high in people's esteem," were other answers.

Ages of the girls answering range from 17 to 32. The 32-year-old is now the exception, though it was the average age when the first modern school of nursing opened, 75 years ago. Eighteen is now the average age, anyone over 25 a rarity.

Books the girls said influenced them include the Sue Barton, Cherry Ames and Penny Marsh series, biographies of Florence Nightingale and Clara Barton, Burma Surgeon, The Citadel, The Story of Dr. Wassel and many others. Movies ranging from news reels of warfront action to "Madam Curie" also created an interest in the profession. Radio programs, daytime serials, Red Cross shorts, and "We the People," all brought recruits. Many had seen professional pamphlets and journals, probably through school vocational guidance programs.

In spite of all these influences, there still is a shortage of student nurses. The number enrolled in the fall classes falls 118 below what it should be, although some hospitals have their quotas exactly filled. At present 242 are needed for the schools having spring classes so there still is need to interest girls in becoming nurses. And judging from this survey, you can't start too young.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Mountain, G. E.: Bronchial Asthma, J. Iowa M. Soc. 35:324 (Aug.) 1945.

Voice of Medicine

To the members of the Indiana State Medical Association:

AIMS AND PURPOSE OF THE INDIANA ACADEMY OF GENERAL PRACTICE

On Wednesday, February 9, 1949, the Indiana Academy of General Practice is having its first annual meeting. This meeting will be the culmination of many months of hard work by the officers, directors, and general members of the Academy.

During these past months, the Indiana Academy membership has grown to 300, and basic organization and planning has arrived at a stage whereby the Academy feels that a state meeting will now be not only necessary but successful.

There has been no emphasis placed on any type of scientific meeting until now because it was felt that organization came first and that a really good and well-organized meeting would be more appreciated.

The Academy thus is fortunate in procuring for its first meeting Dr. Walter Alvarez of The Mayo Foundation. As everyone knows, Doctor Alvarez is one of the topnotch writers and speakers of the country.

An afternoon meeting is to be held at the Indiana University School of Medicine, beginning at 1:30 P.M. At this time there will be a program, as follows:

1. Virgil McCarty, M.D., Princeton, will speak on "Appendicitis in the Small Hospital."
2. John VanNuys, M.D., Dean of the Indiana University School of Medicine, will speak on "Educational Needs for the General Practitioner." Here will be an opportunity for the men from all over the state to interject their comment and questions.
3. Walter Kelly, M.D., Indianapolis, will speak on "Socialized Medicine"—a subject which Doctor Kelly knows a great deal about and one in which we are all vitally interested.
4. Walter Portteus, M.D., Franklin, will direct a panel discussion on "Tricks of Office Practice" and "Medical Economics." The panel will be made up of doctors selected by Doctor Portteus. Questions and discussion will be open to the floor and should prove very interesting.

Following the above a business meeting will be held. At this time there will be several important business matters to be brought before the Academy. Among the most important are the reading and adoption of a Constitution and By-Laws of the State Academy and the election of officers, directors and delegates.

In the evening, a dinner meeting will be held in the Indianapolis Athletic Club, jointly with the Indianapolis Medical Society. At this meeting

Doctor Alvarez will speak. Your wives are cordially invited.

All members of all county medical societies are invited to participate, whether or not they are members of the Indiana Academy of General Practice. It is our feeling that it will be a program of sufficient interest to everyone and we sincerely hope that all who can possibly attend will do so. Each county society secretary has reservation blanks for this dinner. Reservations must be in the hands of Dr. Russell Spivey, Indianapolis, by February 5.

In past years, and most unhappily so, we have heard and seen phrases constantly cropping up with "General Practitioner" or "Specialist" used in a misconstrued, if not a derogatory sense—dependent, of course, on who was speaking or writing. We feel that such usage is not only unhappy but entirely wrong. It is past time that we should align ourselves on the side of "doctors," not specialists, not general practitioners. After all, we are all M.D.'s. We simply decided on slightly different fields of medical endeavor. None of us went into surgery because we thus could make more money or friends; and none of us went into E.N.T. because it offered a highly successful career in medicine; no more than we entered general medicine because we love to make night calls. We, as doctors, simply turned to the field in medicine that we thought we would like to do and in which we could be of more aid to the public.

One of the great aims of the Indiana Academy of General Practice is to further and abet the county medical society, the state medical association and the American Medical Association, in each case as a whole. It is time for doctors to work together and be organized into a solidly cemented group which will strive toward one goal.

Any newly organized group such as the Indiana Academy of General Practice must perchance arouse some degree of fear, lest it get "out of hand," so to speak. One of the very best refutations of this fear and one of the most pertinent reasons why the "specialists" per se should be heart and soul in favor of the Academy is to be found in the History of British Medicine.

What group of doctors in England was large enough that, by their vote, could submit all of medicine to government control. The general practitioner, of course. Because the general medical men were not organized, groups of them broke ranks through fear and ignorance of government. There was no cohesive action and consequently no power to resist. In this country, which has approximately 100,000 general practitioners as against a much smaller number of those in spe-



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cialties, the same condition could arise. The specialty groups are well organized, as they should be, but on a total vote could not defeat a government measure unless their friends, the general practitioners, voted likewise. It is entirely conceivable that a situation could arise here in entirely the same manner as it arose in England. Thus, the specialist as such should be heart and soul in favor of a strong, well led organization of general practitioners, an organization which, together with the other groups, would make the medical society itself intrinsically strong. We should and must bear in mind that it is the "Medical Society" which is the parent and guardian of each and every doctor. It is the "Medical Society" which should be backed and abetted by the efforts of all of us.

We hear at various times and places that the

doctors should have a union. Isn't it apparent that with concerted, organized action we could make the medical society our union? Not a union in the sense of the coal miners or plasterers, but a union of doctors working for the good of medicine and the welfare of the American Public.

We, of the Indiana Academy of General Practice, invite your interest and your help in making medicine stronger.

Again may I, on behalf of the Indiana Academy of General Practice, extend to you a cordial invitation to attend the dinner meeting with us to hear Doctor Alvarez, February 9, 1949?

Arthur N. Jay, M.D.
Indiana Academy of
General Practice

VETERANS ADMINISTRATION

Washington, D. C.

Dr. Morris Fishbein
Editor, The Journal of the
American Medical Association
535 North Dearborn Street
Chicago, Illinois

Dear Dr. Fishbein:

It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so-called "Home Town Medical Care Program for Veterans." It has been contended that the Veterans Administration has arbitrarily established a fee schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a national fee schedule. It has also been contended that the various state medical societies and other interested groups were not consulted when this fee schedule was adopted.

In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a national schedule of fees, nor do I contemplate doing so. However, the fee schedules originally submitted by the various state medical societies, when the "Home Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform fee schedule format and to set up tentative fees which could be used as a guide by the various state medical societies when submitting their proposals for the furnishing of medical care to veterans.

This uniform fee schedule format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all

parts of the country. Tentative fees were set up in the format after a careful analysis of Pre-Paid Medical Care Plans, Workmen's Compensation and Insurance Fee Schedule, and also the fee schedules in effect in the various states having agreements with the Veterans Administration. As was to be expected, considerable variation occurred in the fee schedules reviewed.

The Professional Group of National Consultants made every effort to arrive at fees that were considered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between state medical societies and the Veterans Administration.

Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA," which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the medical society concerned.

May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or national fee schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

If it meets with your approval, I would appreciate it very much if you could possibly arrange to publish this as an open letter in the Journal of the American Medical Association. I should like this to reach all of the physicians throughout the country, and I know of no better way to do it than through the Journal.

Very truly yours,

(Signed) PAUL B. MAGNUSON,
Chief Medical Director.

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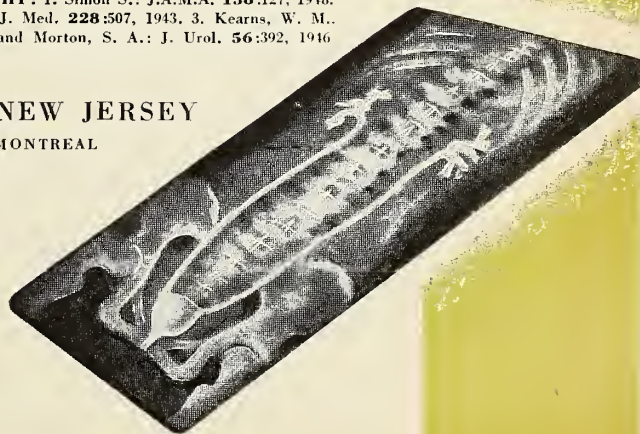
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News Notes

Miss Beverly Kathryn Carlson, of Chicago, and Dr. F. Lamont Jennings, of Indianapolis, were married on December 15 in Bond Chapel on the University of Chicago campus. Doctor Jennings is the son of Dr. and Mrs. Frank L. Jennings, of Indianapolis, and is a graduate of the Indiana University School of Medicine.

Dr. Walter L. Portteus, of Franklin, has been appointed by Governor Ralph F. Gates as a member of the Indiana Council for Mental Health, to fill the vacancy occasioned by the death of Dr. Norman M. Beatty. The appointment is for a four-year term. Doctor Portteus is president of the Indiana Public Health Association, a member of the Executive Committee of the state association, and is a trustee-at-large of the national Blue Shield Commission.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

The first International Congress on Rheumatic Diseases ever held in the United States will take place at the Waldorf Astoria in New York City May 30 to June 3, 1949, inclusive. This seventh International Congress is sponsored by the International League against Rheumatism. The host is the American Rheumatism Association in cooperation with the New York Rheumatism Association.

Seven (five morning and two afternoon) scientific sessions are planned. Also five one-hour round table conferences on various clinical topics will be held under the leadership of authorities in the respective fields. Short clinics, papers and reports will be given concurrently at four or five New York hospitals during three afternoons. Evening entertainment will be provided. The registration fee is \$10.00.

POSTGRADUATE COURSE IN DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians and the Laennec Society of Philadelphia announce a Postgraduate Course in Diseases of the Chest to be held at the Warwick Hotel, Philadelphia, February 28 through March 5, 1949. This course will emphasize the recent developments in all aspects of diagnosis and treatment of diseases of the chest. The course is open to all physicians, although the number of registrants will be limited. Applications will be accepted in the order in which they are received. The tuition fee is \$50.00. Application may be made through the Executive Offices of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10.

The January 22 issue of The Saturday Evening Post has an excellent editorial entitled "State Medicine Hasn't Worked Any Miracles." Don't fail to read it!

ARMED FORCES MEDICAL ADVISORY COMMITTEE

Secretary Forrestal has announced the appointment of the Armed Forces Medical Advisory Committee which will advise the Armed Forces about medical policies and programs. The committee succeeds the Hawley Committee. Charles Proctor Cooper, president of the Board of Trustees of the Presbyterian Hospital, New York City, is designated as chairman. Other members of the committee are: Dr. Maurice C. Pincoffs, Dr. Edward D. Churchill, Dr. Richard L. Meiling, Dr. Howard A. Rusk, Dr. Paul Titus, Dr. Paul Hawley, Dr. Michael DeBakey, Dr. Walter H. Schere (dentist), Dr. Raymond B. Allen, and the three Surgeons General.

MEDICAL SCHOOL ALUMNI MEETING SET FOR 1949

Wednesday, May 11, 1949, has been designated as the second annual Alumni Day for graduates of the Indiana University School of Medicine. The 1949 event will not conflict with the annual Founders' Day program of the University, scheduled for Wednesday, May 4.

Preliminary arrangements for the staging of the second big reunion of Medical School alumni have been started by Chairman Merrill Davis, Marion, and Secretary J. Neill Garber, Indianapolis, with the expectation of bringing more alumni to the Medical Center campus. Dr. Davis and Dr. Garber were named chairman and secretary of the temporary organization formed at the 1948 meeting, with a permanent alumni organization of medical graduates to be formed at the 1949 session.

Approximately 500 applications for membership in the Medical School alumni group, issued in combination with membership in the University's Alumni Association, have been received and it is anticipated that this number will have been doubled by the time of the 1949 meeting.

Plans for holding several class reunions in connection with Alumni Day, including meetings of classes graduated from medical schools prior to the establishment of the Indiana University School of Medicine, have been announced.

Dr. George S. Rader, of Indianapolis, has been appointed assistant professor of neurology and psychiatry at the Indiana University School of Medicine. Doctor Rader was separated from service in August 1946, following which he took postgraduate work in neurology and psychiatry at the University of Pennsylvania Graduate School of Medicine, and then spent a year as a Research Fellow at the Institute of Pennsylvania Hospital, in Philadelphia. He has been in practice at 822 Hume Mansur Building, in Indianapolis, since October 1948.

**DR. STANLEY COBB TO DELIVER SALMON
LECTURE SERIES FOR 1949**

Dr. C. Charles Burlingame, chairman of the Salmon Memorial Committee, has announced the selection of Dr. Stanley Cobb as the Salmon Memorial Lecturer for 1949. Dr. Cobb, president of the American Neurological Association, is one of the most renowned researchers, writers and educators in the field of medicine. He has been Bullard Professor of Neuropathology at Harvard Medical School since 1926, and for the last fifteen years Psychiatrist-in-Chief of the Massachusetts General Hospital.

The Salmon Committee, appointed by the New York Academy of Medicine, selects each year a specialist in the fields of psychiatry, neurology or allied fields either in this country or abroad who has made an outstanding contribution to his specialty. Begun in 1932, the lectures have had an outstanding array of specialists including Dr. Adolf Meyer, Dr. C. Macfie Campbell, Dr. William White, Dr. Samuel T. Orton, Dr. William Healy, Dr. David Henderson, Dr. Edward Strecker, Dr. Nolan D. C. Lewis, Dr. Robert Dick Gillespie, Dr. Emilio Mira, Dr. Abraham Arden Brill, Dr. John Rawlings Rees, Dr. Roy Graham Hoskins, Dr. David M. Levy, Dr. Harold Dwight Laswell, and Dr. Torbjørn O. Caspersson.

Dr. Nelson N. Kaufman began the practice of gynecology and obstetrics on January 3 in the offices of Dr. J. William Hofmann, at 323 Hume Mansur Building, in Indianapolis. For the past three years Doctor Kaufman has been at Indianapolis General Hospital, in the Department of Gynecology and Obstetrics, during which time he was in charge of Outdoor OB at the Indiana University Medical Center. He graduated from the Indiana University School of Medicine in 1938, and took a two-year internship at Indianapolis General Hospital. After a five months' residency in gynecology and obstetrics, he went into service in October, 1940. He served with the 31st Infantry of the Philippine Division; was captured on Bataan in April, 1942; and was sent to Japan in November, 1942, where he remained until he was liberated in October, 1945. He was separated from service on July 28, 1946, and while on terminal leave he began his residency, in March, 1946, at Indianapolis General Hospital.

Federal Security Administrator Oscar R. Ewing recently announced the appointment of Dr. Paul H. Keyes to fill a vacancy on the Employees Compensation Appeals Board. Doctor Keyes is a graduate of the Medical College of Indiana, in Indianapolis, in 1901, and has had more than ten years experience in employees compensation work in various agencies of the Federal Government. In addition to the new appointee, the three-member Appeals Board includes Henry C. Iler, Chairman, and former Senator Hattie W. Carraway.

The laboratory of the Indiana State Board of Health has been announced as one of the laboratories cooperating with the Public Health Service, in a plan designed to study possible future epidemics of influenza.

The specific objectives of the program are (1) to identify new strains of influenza virus as these appear, and (2) to evaluate their usefulness for incorporation of influenza vaccine.

In the event of an outbreak of respiratory disease suspected of being influenzal in nature, regional laboratories throughout the United States will conduct serological tests to determine the nature of the disease. Strains of the influenza virus will be isolated, and if new strains are discovered, the U. S. Army Epidemiological Board at Long Island College of Medicine will conduct a complete antigenic analysis.

Appropriate strains of the virus which may be isolated will be considered for possible inclusion in commercial vaccine.

**POSTGRADUATE CENTER FOR
PSYCHOTHERAPY, INC.**

The Postgraduate Center for Psychotherapy, Inc., the training associate of the Institute for Research in Psychotherapy, Inc., has been granted a provisional charter from the Board of Regents of the New York State Educational Department. It offers intensive training for psychiatrists in psychotherapy leading to certification; also individual courses for general practitioners and non-psychiatric medical specialists in psychotherapy and psychosomatic medicine.

The primary aim of the program is to encourage the development of teams of psychiatrists, psychologists, and social workers who can organize and operate community psychiatric clinics.

Further information on this program may be obtained by writing to Stephen P. Jewett, M.D., Dean, or to Miss Janice Hatcher, Registrar, Postgraduate Center for Psychotherapy, Inc., 218 East 70th Street, New York 21, New York.

The University of Michigan Department of Postgraduate Medicine has announced that they will give eleven postgraduate courses during the spring of 1949. Requests for information should be addressed to Howard H. Cummings, M.D., chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

At a meeting of the Indiana Association of the History of Medicine which was held recently in the State Library at Indianapolis, Dr. William M. Loehr, of Indianapolis, was elected president. Dr. William D. Inlow, of Shelbyville, was elected vice-president, and Mrs. Dorothy R. Russo, of Indianapolis, was elected secretary.

Dr. Marvin Sandorf, of Indianapolis, recently passed the Indiana State Bar examination, and is now permitted to practice law, as well as medicine. He has practiced medicine in Indianapolis for a number of years, and took up the study of law as a hobby. Doctor Sandorf is one of only four or five men in the United States who holds both an M.D. and an L.L.D. degree.

AMERICAN ACADEMY OF GENERAL PRACTICE

The first annual session of the American Academy of General Practice will be held in Cincinnati on March 7, 8 and 9, 1949.

The following members of the Indiana Academy of General Practice have been placed on a mixer committee to serve with other men from Kentucky and Ohio, to greet those doctors coming from all over the country: John K. Jackson, M.D., Aurora; Albert M. Donato, M.D., Indianapolis; James M. Pfeifer, M.D., Lawrenceburg; Charles P. Schneider, M.D., Evansville; Hugh Ramsey, M.D., Bloomington. Alternates for this committee consist of Frank W. Oliphant, M.D., Mt. Vernon; Lloyd E. Foltz, M.D., Brownsburg; and John S. Huoni, M.D., Jeffersonville.

The Northern Tri-State Post-Graduate Medical Association will hold its 76th annual "Graduate Assembly" in Fort Wayne, on April 12, 1949, at the Chamber of Commerce Auditorium. A full-day medical program of general interest is planned. The detailed program will appear in the March issue of THE JOURNAL.

ATTENTION: PHYSICIANS, HOSPITALS AND INSTITUTIONS

Due to a change of postal regulations, effective January 1, 1949, the rates for mailing bacteriological and blood specimens to the Indiana State Board of Health Laboratories have been increased. Please check with your local postmaster concerning these new rates. This will avoid any delay in the delivery of the specimens to the State Board of Health which might be caused by the postal department holding them for inadequate postage.



Miss Betty Malinka was the recipient of the 1948 Oberlin Award from the Lake County Medical Society at their Fiftieth Anniversary Dinner in Gary in December. Miss Malinka was largely responsible for legislative authorization of Gary's full-time city health department. Established in 1942 in memory of the late Thomas W. Oberlin, of Hammond, the award is reserved for lay persons in the county in recognition of distinguished service in contribution to the health of the people of the area.

A citation accompanying the award stated that it was presented to Miss Malinka "for her outstanding contributions in securing more and better health legislation in the 1947 meeting of the Indiana General Assembly than in any previous session."

"As a member of the minority party in the House of Representatives, she commanded the respect and affection of all her fellow legislators and of the officers of the general assembly. No matter concerning health received very serious consideration until the opinion of this legislator had been heard."

In addition to having served three two-year terms in the state legislature, Miss Malinka has been a state representative for the National Foundation for Infantile Paralysis for the past five years, and is a member of the State Public Health Association.

The Alembert Winthrop Brayton Skin and Cancer Foundation's program for its clinicopathological conferences for February and March is as follows: February 17, 1949, Hamilton Montgomery, M.D., from the Section on Dermato-Syphilology of the Mayo Clinic, will view clinical out-patient cases at the General Hospital from 8:30 to 9:30, and he will conduct a conference on cases presented at the Lilly Auditorium, at the Indianapolis General Hospital. Following a luncheon in the Staff Dining Room at the General Hospital, there will be a walk through the department facilities. On March 3, 1949, Dr. Francis Eugene Senear, professor of Dermato-Syphilology of the University of Illinois, Chicago, will be the guest speaker at the annual clinical meeting commemorating the birthday of Dr. Alembert Winthrop Brayton.



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Deaths

James York Welborn, M.D., prominent surgeon of Evansville, died on December 21 after a long illness, at the age of seventy-five. He had retired approximately two years ago due to ill health. He graduated from the Marion-Sims College of Medicine, in St. Louis, in 1899. Doctor Welborn had taken an active part in public health work, having helped to found the Boehne Tuberculosis Hospital. He had been on the staff of the Welborn Hospital for more than forty years, and had purchased the hospital in 1922. He was a charter member of the American College of Surgeons, and was a member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



Wallace Weston Tate, M.D., of Thayer, died on December 13 after a brief illness. He was seventy-three years of age. A graduate of the Harvey Medical College, of Chicago, in 1903, Doctor Tate had practiced in Thayer ever since that time. He was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Samuel Dunham Bader, M.D., retired physician of Columbia City, died on December 12, at the age of ninety-nine. He was a graduate of the Chicago Homeopathic Medical College, in 1897, and began the practice of medicine in Fort Wayne. He had practiced in Whitley County since 1905.

Victor F. Tremor, M. D., of Indianapolis, died at the Veterans Hospital in Indianapolis, after an illness of four years. He was fifty-two years of age. He was a veteran of both World Wars, and had served as chief of surgical service at the Cold Springs Veterans Hospital for seven years before his illness. Doctor Tremor was a graduate of the Indiana University School of Medicine in 1923, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

A. L. Barnes, M.D., former Southport physician for many years, died on December 17 in Los Angeles. He was eighty years of age. He had moved to Seattle, Washington, more than thirty years ago, where he practiced for many years. He had moved to California only two years ago, when his health began to fail.

Lowell McKee Green, M.D., of Rushville, died suddenly on January 3 at his home. He was sixty-six years of age. Doctor Green was a graduate of the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1906. Doctor Green had retired prior to World War II, but came out of retirement because of the shortage of physicians. He had specialized in obstetrics. He was a member of the Rush County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.





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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

December 12, 1948

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Walter L. Portteus, M.D.; Cleon A. Nafe, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., associate editor of *THE JOURNAL*; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: L. E. Burney, M.D., director, State Board of Health, and Don E. Wood, M.D.

Membership Report

Number of members December 11, 1948	3,675*
Number of members December 11, 1947	3,604
Gain over last year	71
Number of members December 31, 1947	3,618
* Includes 55 in military service (gratis)	
179 honorary members	

Statements of receipts and expenditures for October and November for the association and *THE JOURNAL* were approved.

Treasurer's Office

The recommendation of the treasurer that \$5,000 worth of United States savings bonds be purchased out of the general fund was approved upon motion of Drs. Nafe and Ellison.

Audit of the books by George S. Olive and Company was approved on motion of Drs. Portteus and Nafe.

1949 Annual Session, Indianapolis, September 26-29, 1949

Length of meeting. On motion of Drs. Ellison and Nafe, the Committee decided that the meeting should be of four days' duration, beginning on Monday, September 26, 1949.

Legislative Matters

National

The executive secretary reported that he had written to all Indiana congressmen asking for an appointment to talk with them about the proposed Truman-Ewing compulsory sickness insurance bill.

The field secretary submitted a questionnaire and explained how it would be used by college classes in procuring opinions on the subject of socialized medicine. The idea was approved on motion of Drs. Hauss and Nafe.

The field secretary asked permission to do a newscast on Sundays over one of the Indianapolis radio stations. The sponsor of the program is unknown at present. The request was approved on motion of Drs. Nafe and Ellison.

On motion of Drs. Nafe and Portteus the executive secretary was directed to write to the chairman and secretary of the Indiana Inter-Professional Health Council to ask that all professions represented take an active part in the campaign against compulsory sickness insurance.

Local

On motion of Drs. Portteus and Ellison, the committee voted to sponsor a dinner at the Columbia Club, Indianapolis, on Wednesday night, December 29, to which drug manufacturers, the dental profession, the hospital association and other allied professions and industries are to be invited to decide upon a plan for the group to put on an educational campaign against socialized medicine within the state. The chairman of the Executive Committee is to select the organizations to be represented at the dinner.

The state health commissioner discussed the bill for codification of health laws and a second bill which will ask for state finances for full-time health units and training facilities for health units personnel. On motion of Drs. Portteus and Hauss the legislative program of the State Board of Health was approved in principle.

The state health commissioner reported that a compromise had been reached in the controversy between public health officials and the Hoosier State Press Association which concerned release of vital statistics information.

Proposed Heart Survey in Indiana by the U. S. Public Health Service

Dr. Don E. Wood, representing the Committee on Heart Disease of the Indiana State Medical Association, reported on a conference with Dr. Chapman of the U. S. Public Health Service about a heart survey in Indiana similar to one which had been conducted in Newton, Massachusetts. He explained that the U. S. Public Health Service would send an officer to Indiana to work in liaison with the state medical association, the Indiana Heart Foundation, and the Indiana State Board of Health in making plans for the survey. It was explained that no survey will be made in any community without the approval of the local county medical society. On motion of Drs. Hauss and Portteus the committee approved the sending of an officer to Indiana to make preliminary preparations for the survey.

Postgraduate Study

The request of the Allen County Medical Society for funds to use in a postgraduate course was deferred, on motion of Drs. Hauss and Nafe, pending a complete report to the Council from the Committee on Medical Education and Hospitals.

Guide posts...

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Organization Matters

A.M.A. assessment. The preparation of a receipt book by the headquarters office to be sent to each county medical society secretary for collection of the assessment through the headquarters office was approved on motion of Drs. Nafe and Ellison.

1949 membership in the American Public Health Association was approved on motion of Drs. Nafe and Ellison.

Suggestion of an Indianapolis physician that the statement, "You Are the Government" be printed in large letters, framed and sold to physicians was taken under advisement.

On motion of Drs. Nafe and Ellison the Indiana State Medical Association will reserve rooms at Atlantic City in June for headquarters during the summer meeting of the American Medical Association.

On motion of Drs. Nafe and Hauss, a \$50.00 membership in the Conference of Presidents was voted.

Purchase of a new mimeograph was approved on motion of Drs. Nafe and Hauss.

On motion of Drs. Ellison and Nafe, the committee recommended to the new Committee on Public Relations that ISMA News Flashes be continued through 1949 and that they be mailed to all members of the association.

On motion of Drs. Nafe and Ellison the executive secretary was instructed to write a letter of sympathy, upon behalf of the committee, to Mrs. Norman M. Beatty.

The Journal

Report on advertising:

Increase in November	\$ 181.57
Decrease	40.80
<hr/>	
Total increase, November	\$ 140.77
Total increase for year	\$2,674.57

Letter from C. E. Pauley and Company making known the fact that there will be a 13% increase in printing costs of THE JOURNAL, beginning January 1, 1949, was read. On motion of Drs. Nafe and Ellison it was decided to continue the contract with the Pauley Company for the time being.

COMMITTEE ON PUBLICITY

December 3, 1948.

Present: Homer G. Hamer, M.D., chairman; James O. Ritchey, M.D.; Larry Richardson, field secretary, and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of January 17, 1949—"Watch Your Step."

"Week of January 24, 1949—"Athlete's Foot."

Week of January 31, 1949—"Convulsions."

A news release entitled, "Doctors Caution Women Shoppers to Take It Easy," for daily newspapers, was approved.

The field secretary was chosen to address the Gibson County Medical Society October 10, 1949, on "Medical Economics," in response to a request for a speaker.

The committee approved preparation of five-minute radio transcriptions on the subject of compulsory sickness insurance for consideration at the next meeting.

COMMITTEE ON PUBLICITY

December 17, 1948

Present: Homer G. Hamer, M.D., chairman; James O. Ritchey, M.D.; Marlow W. Manion, M.D.; Cleon A. Nafe, M.D.; Larry Richardson, field secretary, and Ray E. Smith, executive secretary.

The following "Hints on Health" column was approved:

Week of Feb. 7, 1949—"Trench Foot."

The field secretary presented two sample five-minute radio transcriptions. After hearing them, the committee voted to proceed with the preparation of a series of thirteen five-minute platters pointing out to the public the evils of socialized medicine, which county medical societies may borrow for use over local radio stations.

Dr. Carl H. McCaskey, chairman of the Executive Committee, appeared before the committee to discuss plans of the Executive Committee for enrolling allied organizations, including pharmaceutical firms, in the fight against socialized medicine.

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Secretary-Treasurer, C. P. Fox, Washington.

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President, G. A. Held, Jasper,
Vice-President, C. H. Klammer, Jasper,
Secretary-Treasurer, J. M. Wagoner, Huntingburg.

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President, B. J. Smith, Kingman,
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Secretary-Treasurer, A. A. Freed, Attica.

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President, Orville M. Graves, Princeton,
Vice-President, G. E. Fisher, Owensville,
Secretary-Treasurer, R. E. Weitzel, Princeton.

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City.

LOCAL SOCIETY REPORTS

Clinton County Medical Society members held a meeting at the Clinton County Hospital in Frankfort, on January 4. The guest speaker was State Representative Harold P. Heavilon. Twenty-one members were present.

Dubois County Medical Society members met at Huntingburg on December 2 for a general business meeting and election of officers. Thirteen members were present.

Elkhart County Medical Society held a meeting on December 2 at the Hotel Elkhart in Elkhart. Election of officers was held, and Dr. Lester Ericksen, of South Bend, showed color slides of a recent trip through Norway, Holland and Switzerland. Seventy members and guests were present.

Fayette-Franklin County Medical Society members met in Connersville on December 14. Seventeen members were present.

Greene County Medical Society members held a meeting at the Freeman Greene County Hospital in Linton on December 16. Fifteen members were present. Mr. Edward Morris, Enrollment Director of Blue Cross and Blue-Shield, spoke on "Medical Prepayment Plans."

Hancock County Medical Society members met at the Riley Hotel in Greenfield on December 8. Mr. V. W. Abraham, special investigator for the Indiana Board of Medical Registration and Examination, spoke on the functions of that board. Election of officers was held.

Henry County Medical Society members met at the Westwood Country Club in New Castle on December 14. Wives of the members were guests at this meeting. The principal speaker was Dr. John Van Nuys, of Indianapolis, dean of Indiana University School of Medicine. He spoke on present-day problems in medical education.

Johnson County Medical Society members held a meeting in Greenwood on December 8. This was their annual Christmas dinner meeting, and election of officers was held.

Knox County Medical Society members held a meeting at the Grand Hotel in Vincennes on December 21, when officers for 1949 were elected. Dr. John Flinn of Evansville, was the guest speaker. His subject was "Congestive Heart Failure." Twenty-five members were present.

Kosciusko County Medical Society held a meeting in Warsaw on December 17. This was a business meeting and officers for 1949 were elected. Thirteen members were in attendance.

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Madison County Medical Society members held a meeting at the Anderson Country Club in Anderson, on December 20, when they entertained the Senators and Representatives of the county. Forty-seven members and eight guests were present. Dr. C. L. Willson of Anderson showed colored movies.

Noble County Medical Society members met at the Kendall Hotel in Kendallville, on December 16. Officers for 1949 were elected and a general discussion followed. Nineteen members were present.

Orange County Medical Society members met at West Baden on January 4. The guest speaker was Dr. Morris M. Weiss, of Louisville, whose subject was "Common Drugs Used in Heart Disease."

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital in Clinton on December 15. Dr. Stuart R. Combs, of Terre Haute, spoke on "Allergic Conditions of the Chest." Fourteen members were in attendance.

Tippecanoe County Medical Society members met at Lincoln Lodge, in Lafayette, on December 14. Fifty members were present. Officers for 1949 were elected.

Wells County Medical Society held a meeting at the Bluffton Country Club in Bluffton on December 15. This was their annual Christmas meeting, and members of the Woman's Auxiliary were present. Thirty-two members and guests were present.

Whitley County Medical Society members met on December 14 at Columbia City. The nine members present heard Dr. Frank Thompson, of Columbia City speak on "Sodium Free Diet in the Treatment of Cardiac and Hypertensive Disease."

Vanderburgh County Medical Society members held their annual business meeting at the Hotel McCurdy on December 14. Officers for 1949 were elected.

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

A.M.A. INTERNS' MANUAL. 209 pages. Cloth. Price \$2.25. Philadelphia and London, W. B. Saunders Company, 1948.

PHYSICIAN'S HANDBOOK. By John Warkentin, M.D., and Jack D. Lange, M.D. Fifth Edition, 294 pages. Paper. Price \$2.00. University Medical Publishers, Palo Alto, California.

ANESTHESIA: PRINCIPLES AND PRACTICE. A Presentation for the Nursing Profession. By Alice M. Hunt, R.N. 148 pages, with 7 illustrations. Fabrikoid. Price \$2.60. G. P. Putnam's Sons, New York, 1948.

THE CASE AGAINST SOCIALIZED MEDICINE. By Lawrence Sullivan. 53 pages. Cloth. Price \$1.50. The Statesman Press, Washington, D.C., 1948.

WHICH WAY OUT. By C. P. Oberndorf, M.D., clinical professor of psychiatry, Columbia University. 236 pages. Cloth. Price \$3.25. International Universities Press, New York, 1948.

PSYCHIATRY IN GENERAL PRACTICE. By Melvin W. Thorner, M.D., assistant professor of neurology, The Graduate School of Medicine, University of Pennsylvania. 659 pages. Cloth. Price \$8.00. W. B. Saunders Company, Philadelphia, 1948.

HUMAN BIOCHEMISTRY. By Israel S. Kleiner, Ph.D., professor of biochemistry, and director of the Department of Physiology and Biochemistry, New York Medical College. Second edition. 649 pages, with 77 illustrations and 5 color plates. Price \$7.00. The C. V. Mosby Company, St. Louis, 1948.

EDUCATION FOR PROFESSIONAL RESPONSIBILITY. A report of the proceedings of the Inter-Professions Conference on Education for Professional Responsibility, held at Buck Hill Falls, Pennsylvania, April 12-14, 1948. 207 pages. Cloth. Carnegie Press, Pittsburgh, 1948.

BOOKS REVIEWED

ESSENTIALS OF PATHOLOGY. Third Edition. By Lawrence W. Smith, M.D., formerly Professor of Pathology, Temple University School of Medicine. 764 pages, with 740 illustrations. Fabrikoid. Price \$12.00. The Blakiston Co., Philadelphia, 1948.

In this third edition of the work the authors have again presented only the essentials of pathology, making the volume more beneficial to the student, intern and resident. They have done this by a description of general and specific pathological processes, case histories and by many excellent illustrations, all of these making the study of pathology more easily comprehended.

The twenty pages of bibliography in the back give the readers a selected group of reading for more information on the numerous subjects covered by the authors.

CORONARY HEART DISEASE. By A. Carlton Ern-stene, M.D., chief of the section on cardiovascular disease, Cleveland Clinic, Cleveland, Ohio. 102 pages. Fabrikoid. Price \$2.50. Charles C. Thomas, Publisher, Springfield, Illinois, 1948.

In this compact little volume of 102 pages the author has covered the subject of "Coronary Heart Disease" in a very concise, comprehensive manner.

The principal clinical manifestations are discussed and each is treated in detail with regard to pathology, symptoms, diagnosis, complications, prognosis and treatment. The subject matter is presented in an easy to follow form and should be helpful to practitioner and student alike.

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J. H. Grimes, M.D., Associate

THE FOOT AND ANKLE—THEIR INJURIES, DISEASES, DEFORMITIES AND DISABILITIES—(Third Edition). By Philip Lewin, M.D., Professor of Bone and Joint Surgery and Acting Head of Department, Northwestern University Medical School; Professor of Orthopedic Surgery, Postgraduate Medical School, Cook County Hospital. Philadelphia: Lea & Febiger, 1948. 847 pp., 389 illus. \$12.00.

In this third edition the author has made many revisions. Most of these revisions are the result of advances in the use of Chemotherapy and treatment of foot and ankle conditions as experienced in the recent World War.

This book, as well as the other editions, present a thorough coverage of treatment and diagnosis of problems arising in the foot and ankle. Not only is the author's approach practical, but it is also detailed, and the most important phases have been well covered. There are numerous references, all well-chosen.

MODERN CLINICAL PSYCHIATRY. By Arthur P. Noyes, M.D., Superintendent, Norristown State Hospital, Norristown, Pennsylvania. Third edition. 525 pages. Cloth. Price \$6.00. W. B. Saunders Company, Philadelphia, 1948.

The stress of modern life may be no worse than the stress of ancient days, but it has become increasingly evident since the two great wars that the problems of modern man have eaten into his mind like subterranean running water eats into the limestone rock. A very great number of the disabling casualties of the last war were due to psychoneurotic problems.

Only in the last decade has psychiatry evolved into an accepted, distinct branch of medicine dealing with the investigation, diagnosis, and treatment of disturbed personality functions.

The present book is based on a series of lectures delivered at a large State Hospital for Mental Disease. The material is presented in psychobiological terms, or as a consideration of the working of the organism as a whole as it influences personality. The problem often presents itself to the patient when he attempts to deal with personality problems and maladjustments and cannot find a satisfactory answer.

This five hundred and twenty-five page book deals with all the recognized problems of psychiatry but necessarily in a succinct manner, giving a pertinent bibliography at the end of each chapter for further study. There is a chapter on shock treatment in therapy with a suggestion of softening seizures by using curare and a discussion of what may be expected from prefrontal lobotomy. The last chapter is on child psychiatry.

As an introduction to psychotherapy in the general practice of medicine the author quotes from Socrates, "Let no one persuade you to cure him until he has first given you his soul to be cured, for this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."

Psychotherapy is considered under two headings: first, the genetic-dynamic approach where an attempt is made to have the patient understand his own personality problems and heal himself; and second, the supportive methods of treatment not specifically directed at the cause of the illness such as persuasion, suggestion, hypnosis and mental catharsis.

The book reads with much ease.

Pierce MacKenzie, M.D.

SYMPOSIA ON NUTRITION — NUTRITIONAL ANEMIA. Edited by Arthur Lejwa. 194 pages, with 78 illustrations. Fabrikoid. The Robert Gould Research Foundation, Inc., Cincinnati, 1947.

Each of the subjects in this volume has been presented by different men who prepared their papers for the Symposium on Nutritional Anemia which was organized by The Robert Gould Research Foundation.

A few of the subjects included in Volume I are physiological implications of the anemic state, treatment of nutritional anemias with folic acid, iron metabolism and hypochromic anemia and the vitamins and anemia. The information has been supplemented by graphs, scales, et cetera, and each has a complete list of references. Each of these papers is a credit to the men who prepared them and to the Foundation.

A - B - C's OF SULFONAMIDE AND ANTIBIOTIC THERAPY. By Perrin H. Long, M.D., Professor of Preventive Medicine, Johns Hopkins University School of Medicine. 231 pages. Fabrikoid. Price \$2.50. W. B. Saunders Company, Philadelphia, 1948.

Most of us have been looking for this small volume which gives concise information on the use and effect of the sulfonamides, streptomycin and penicillin. In covering 156 diseases the author has given the etiology, specific therapy, auxiliary therapy and comments of each with as few words as possible but enough to cover each thoroughly.

This book is of value because of its size, making it easy to carry and readily accessible at any time.

THE BATTLE OF THE CONSCIENCE. By Edmund Bergler, M.D., Washington, D. C. 296 pages. Cloth. Price \$3.75. Washington Institute of Medicine, Washington, D. C.

In this book the author shows how the conscience is a dynamic positive force, everything depending on the conscience whether it is approving or accusing. He shows how we appease the super-ego by unconscious bargaining. To help one understand the book better, the author has cited cases and then gives his interpretations of them. It takes much effort to uncover what goes on in the unconscious by the psychiatrist, but the author does just that. For the person with the time and desire to read this volume it will prove to be interesting and enlightening.

WAR, POLITICS, AND INSANITY. By C. S. Bluemel, M.D., (Eng.) 121 pages. Cloth. Price \$2.00. The World Press, Inc., Denver, Colorado, 1948.

Although this book is not instructive, it is interesting and, with the exception of the last chapter, mature; however, we felt that the last chapter, in which the author gives his plan of "Selective Government," was too juvenile.

A few outstanding personages have been studied and from the combined traits of each the author feels their personalities may be either definitely normal or abnormal. He argues that most of the leaders are extroverts and that when the world is run by normal men, we will live together in peace.

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THE ROLE OF ANALGESIA AND ANESTHESIA IN THE PRODUCTION OF ASPHYXIA NEONATORUM†

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WHEN, during the conduct of a labor, delivery is finally achieved, the interest and concern of all those in attendance are centered on the presence or absence of respiratory activity by the newborn infant. If such activity is not immediately demonstrable, the delivery room personnel become preoccupied in attempts, at times quite frantic, to remedy the situation. There is not, at this moment of crisis, opportunity for a careful recapitulation of the events of the labor, nor for speculation as to the factors involved in producing



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the present sad condition of the newborn. The thoughtful physician, however, may well reflect upon this problem in more leisurely moments, and ponder the cause for the staggering numbers of asphyxiated infants who are being born annually in the lying-in units of our hospitals. Presumably, if such reflection revealed that factors were involved over which the physician might exercise some control, he would take alacritous remedial action in his conduct of the course of another labor.

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THE ETIOLOGY OF ASPHYXIA NEONATORUM

The etiological factors capable of inducing asphyxia neonatorum are legion, however, and not all of these are subject to the control of the individual physician (Fig. 1).

The mother herself, for instance, may influence the production of asphyxia unwittingly by such unyielding factors as her age, her parity and her health, and these are certainly beyond the scope of the physician's sphere of influence. It has been found that the age of the mother is of no importance until the age of forty years is reached, but that thereafter the incidence of asphyxia increases markedly.^{1, 2} The parity of the mother is a factor, primiparas giving birth to asphyxiated babies more frequently than multiparas,³ until after the eighth baby, when the incidence of asphyxia increases with parity.⁴ The health of the mother is also a factor: cardiac disease, cardiac failure, anemia, pulmonary disease, infections, diseases of the genito-urinary and gastro-intestinal tracts, metabolic diseases such as diabetes or thyrotoxicosis, deficiency diseases, hypertensive states, and the toxemias of pregnancy, all markedly increase the incidence of asphyxia.^{4, 5, 6, 7, 8}

The products of conception may be the basis for the production of asphyxia neonatorum and thus, again, beyond the control of the physician. The viability of the germ-plasm, and the development

TABLE I
The Role of Morphine and Its Derivatives in the Production of
Asphyxia Neonatorum

Author	Reference No.	Date Published	Patients in Series Reported	Fetal Mortality Uncorrected %	Asphyxia Respiration Delayed %	Resuscitation Required %
von Steinbuechel	42	1903	20	10.0	----	5.0
Gauss	43	1906	500	1.2	23.8	13.0
Hocheisen	44	1906	100	----	18.0	15.0
Gauss	45	1907	500	----	12.7	6.3
Hunt	46	1932	50	----	14.0	----
Irving, Berman and Nelson	27	1934	200	0.5	57.0	----
Lewis	35	1936	109	----	----	14.6
Clifford and Irving	6	1937	100	2.0	57.0	23.0
Rudolph and Dressner	49	1941	52	0.0	----	5.8
Mengert	48	1942	564	5.6	10.8	9.6
Total Cases Reported	----	----	2195	----	----	----
Average Incidence	----	----	----	3.1	21.8	10.7
Total Cases Considered in Averages	----	----	----	1384	2014	1945

mid-forceps, cesarean section, and low forceps delivery without episiotomy are associated, in the order given, with a frequency of asphyxia higher than that with spontaneous delivery.^{2, 3, 4, 6, 8, 19, 21, 22} The role of the physician in the production of asphyxia neonatorum by the election of an unsuitable or more dangerous (to the infant) method of delivery is often a very real one, but lies beyond the scope of this discussion.

Finally, and frequently most importantly, the analgesic drugs and the anesthetic agents and methods employed to allay the pains of childbirth are far too often the basic factors operating towards the production of asphyxia neonatorum. This is the more regrettable in that they are man-made obstacles to normal postnatal respiration, administered by, or at the direction of, the attending physician. The parturient, whose kind but thoughtless accoucheur has kept her comfortable, even to the point of narcosis, during the ordeals of labor and delivery, need not always feel gratitude towards that physician. Indeed, she need feel no gratitude at all if her asphyxiated infant should succumb during the neonatal period or become the victim of the devastating neurological injuries that may follow in the wake of asphyxia neonatorum.^{14, 24, 25, 26}

THE USE OF ANALGESICS AND ANESTHETICS IN THE CONDUCT OF LABOR

It is now recognized that permanent, irreparable damage to the central nervous system, consisting of degenerative changes in the nerve cells, may result from the anoxemia of asphyxia neonatorum,¹⁴ and that the not infrequent sequence of asphyxia and successful resuscitation may be followed by crippling sequelae, including mental inferiority, diminished ability to learn, and mental dullness.^{24, 25, 26} In view of these facts, there is an urgent

need for more detailed reports concerning the incidence of apnea and resuscitation of the newborn following the use of obstetrical analgesics and anesthetics during labor and at the time of delivery. For the touchstone of obstetrical analgesics and anesthetics is not, today, the fetal mortality rate, but the fetal morbidity rate.

Since there are many factors involved in the production of asphyxia neonatorum, there is a small but definite incidence of asphyxia in the newborn even when labor and delivery are conducted without recourse to the use of analgesic drugs and anesthetic agents and methods. Irving, Berman and Nelson have reported that if neither analgesics nor anesthetics were given to the mother, 1.9 percent of the infants failed to breathe immediately at delivery.²⁷ Kotz and Kaufman found that infants born to mothers who had received no analgesic breathed spontaneously within 9.8 seconds of delivery.²⁸ Daro and Stein have stated that 0.7 percent of the infants born to unnarcotized and unanesthetized mothers have delayed respirations, and 1.4 percent are truly asphyxiated.²⁹

In striking contrast to these figures are those extant in the literature concerning the incidence of apnea and the necessity for the resuscitation of infants born to mothers who have received analgesia and anesthesia. All forms of analgesia have been condemned on the basis that they inevitably increase the incidence of asphyxia.^{3, 10, 12, 14, 19} Morphine in particular, and its derivatives, have been criticized,^{8, 28, 30, 31, 32, 33, 34, 35} especially when used in large doses within one to six hours of delivery, and in conjunction with other methods of analgesia and anesthesia.^{6, 33, 36, 37, 38, 39, 40} There is some evidence that the newborn's resistance to anoxia is not decreased by opiates, but that the deleterious effects are due to the marked prolongation of labor⁴¹ and the resultant traumatism to the infant.² In a collected series of 2,195 in-

TABLE II
The Role of the Barbiturates in the Production of
Asphyxia Neonatorum

Author	Reference No.	Date Published	Patients in Series Reported	Asphyxia		
				Fetal Mortality %	Respira- tion Delayed %	Resuscita- tion Required %
Robbins, McCallum, Mendenhall & Zerfas	53	1929	80	1.3	2.6	3.9
Rosenfield & Davidoff	55	1932	50	---	---	10.0
Paxson	56	1932	55	---	42.0	---
Birnberg & Livingston	54	1934	143	---	---	16.1
McGuinness	57	1934	140	0.7	4.2	7.1
Irving, Berman & Nelson	27	1934	660	0.9	41.8	3.3
Lewis	35	1936	147	---	---	4.8
Clifford & Irving	6	1937	260	0.0	37.0	3.0
Emmert & Goldschmidt	58	1938	200	1.0	2.0	2.0
Frech, Volpitto & Torpin	59	1939	375	2.4	---	10.4
Campron	60	1941	94	3.2	3.2	---
Hanley	61	1941	312	0.3	---	3.8
Henderson, Foster & Enos	62	1941	975	1.9	---	6.5
Thomas & Taylor	63	1942	116	---	---	7.7
Mengert	48	1942	243	2.9	5.4	3.2
Daro & Stein	29	1942	173	---	13.8	4.6
Bernstine & Prince	64	1943	119	0.8	14.3	---
Brockman	65	1943	78	1.3	---	3.8
Volpitto	66	1946	170	0.6	---	6.9
Lewis	67	1946	618	3.3	---	14.0
Anderson	68	1947	700	0.6	---	7.1
Lilienfeld & Dixon	69	1947	391	---	---	16.4
Total Cases Reported	---	---	6099	---	---	---
Average Incidence	---	---	---	1.5	22.9	7.6
Total Cases Considered in Averages	---	---	---	5024	2024	5831

stances of the administration of opiates to parturient women (Table I), the uncorrected fetal mortality was found to be 43, or a rate of 3.1 percent of 1,384 newborn infants; the incidence of delayed respirations in the newborn was 440, or 21.8 percent of 2,014 newborn infants; and the incidence of newborns requiring resuscitation was 207, or 10.7 percent of 1,945 newborn infants.^{6, 27, 35, 42, 43, 44, 45, 46, 47, 48, 49}

The barbiturates, when first introduced, were regarded as the answer to the problem of obstetrical analgesia,^{50, 51, 52, 53} but it has become apparent that they, too, contribute to fetal respiratory depression.^{27, 30, 32, 35, 38, 39, 54} In a collected series of 6,099 instances of barbiturate obstetrical analgesia (Table II), the uncorrected fetal mortality was found to be 75, or a rate of 1.5 percent of 5,024 newborn infants; the incidence of delayed respirations in the newborn was 464, or 22.9 percent of 2,024 newborn infants; and the incidence of newborns requiring resuscitation was 446, or 7.64 percent of 5,831 newborn infants.^{6, 27, 29, 35, 48, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69}

Demerol, since its introduction in 1943,⁷⁰ has proved to be less depressing to fetal respiratory activity than the opiates and barbiturates, but nevertheless contributes quite definitely to the incidence of fetal asphyxia. This drug, as well as morphine and its derivatives, appears to be most dangerous to the infant when administered within

three hours prior to delivery, and its use during this interval should be assiduously avoided. In a collected series of 2,649 instances of obstetrical analgesia utilizing demerol during labor (Table III), the uncorrected fetal mortality was found to be 66, or a rate of 2.8 percent of 2,349 newborn infants; the incidence of delayed respirations in the newborn was 175, or 11.9 percent of 1,469 newborn infants; and the incidence of newborn infants requiring resuscitation was 161, or 6.1 percent of 2,649 newborn infants.^{71, 72, 73, 74, 75, 76, 77, 78, 79, 80}

Rectal analgesics have enjoyed a certain vogue in obstetrical practice for a number of years,⁴⁰ but the variation in the route of administration of the analgesic drugs in no way decreases their contribution towards the incidence of fetal asphyxia. The use of a colonic ether-in-oil mixture has resulted in an uncorrected fetal mortality rate of 2.0 percent, and an incidence of newborn infants requiring resuscitation of 6.0 percent.⁸¹ Avertin (Tribromethyl alcohol) administered rectally has resulted in an uncorrected fetal mortality rate of 2.0 percent, and an incidence of newborn infants requiring resuscitation of 5.1 percent.^{46, 82, 83} Pentothal sodium has been administered rectally as an obstetrical analgesic with a reported incidence of newborn infants requiring resuscitation of 10.0 percent.⁸⁴ Paraldehyde instilled into the rectum has resulted in an uncorrected fetal mortality rate of

TABLE III
The Role of Demerol in the Production of
Asphyxia Neonatorum

Author	Reference No.	Date Published	Patients in Series Reported	Fetal Mortality Uncorrected %	Asphyxia	
					Respira- tion Delayed %	Resuscita- tion Required %
Gilbert & Dixon	71	1943	150	1.3	----	8.7
Schumann	72	1944	1000	2.3	10.7	3.0
Gallen & Prescott	73	1944	100	2.0	----	9.0
Spitzer	74	1944	80	0.0	----	6.25
Cripps, Hall & Haultain	75	1944	102	0.0	21.6	3.92
Hori & Gold	76	1944	50	0.0	----	16.0
Flatt	77	1946	200	4.5	21.8	4.5
Maximov	78	1946	300	----	----	4.6
de Senarclaus	79	1946	167	5.25	2.25	8.25
Barnes	80	1947	500	4.2	----	11.0
Total Cases Reported	---	---	2649	----	----	----
Average Incidence	---	---	---	2.8	11.9	6.1
Total Cases Considered in Averages	---	---	---	2349	1469	2649

2.1 percent, and an incidence of newborns requiring resuscitation of 7.3 percent.^{60, 85}

All the anesthetic agents and methods likewise play a part in the production of asphyxia neonatorum, with the possible exception of local infiltration with or without peripheral nerve block.^{19, 34, 86, 87} Indeed, local infiltration, as advocated in this country by Gellhorn, DeLee, Beck and others, has been adjudged the safest obstetrical anesthetic available today,^{88, 89} except when the method is complicated by manifestations of idiosyncrasy to the injected local anesthetic solution.⁹⁰ All general anesthetics used to the point of maternal anesthesia decrease the respiratory response of the newborn.⁶² Nitrous oxide produces marked anoxemia of both the maternal and fetal bloods⁹¹ and its use results in an incidence of newborn infants requiring resuscitation of from 6.0 to 28.3 percent.³¹ It is exceedingly dangerous to the infant in concentra-

tions greater than 85 percent.⁹² Ethylene, while considered by some authorities to be the safest of the general anesthetics for use in obstetrics, caused fetal asphyxia in 13.9 percent of the newborns to whose mothers it was administered.³¹ Cyclopropane increases the oxygenation of the maternal blood, but it is claimed to oxygenate the fetal blood poorly,⁹¹ and, when used in concentrations sufficient for operative delivery, has resulted in an incidence of asphyxia of over 20.0 percent.^{93, 94} Ether depresses intrauterine fetal respiratory activity,⁹⁵ decreases fetal oxygenation,⁹² and causes an incidence of asphyxia of from 4.0 to 28.6 percent.^{94, 96, 97, 98}

Spinal and continuous spinal anesthetics are often almost ideal from the viewpoint of prevention of asphyxia of the infant.^{86, 94, 97} The most serious danger is that of maternal circulatory collapse, with the attendant fetal distress that may

TABLE IV
The Role of Spinal Anesthesia in the Production of
Asphyxia Neonatorum

Author	Reference No.	Date Published	Patients in Series Reported	Fetal Mortality Uncorrected %	Asphyxia	
					Respira- tion Delayed %	Resuscita- tion Required %
Batten	99	1941	96	0.0	----	0.0
Batten	100	1943	25	0.0	----	0.0
Hinebaugh & Lang	101	1944	51	1.9	----	0.0
Heard	94	1946	185	3.3	2.2	3.3
Ullery	102	1946	300	5.3	----	0.0
Risser & Emanuel	103	1946	118	2.5	----	1.7
Parmley & Adriani	106	1947	156	0.0	----	0.0
Marcus, Tunnell & Wilkinson	107	1947	595	?	----	0.8
King & Dyer	108	1947	50	0.0	----	10.0
Schmitz and Baba	109	1947	375	0.8	----	1.6
Total Cases Reported	---	---	1951	----	----	----
Average Incidence	---	---	---	2.1	2.2	1.2
Total Cases Considered in Averages	---	---	---	1356	185	1951

TABLE V
The Role of Caudal Anesthesia in the Production of
Asphyxia Neonatorum

Author	Reference No.	Date Published	Patients in Series Reported	Asphyxia		
				Fetal Mortality Uncorrected %	Respira- tion Delayed %	Resuscita- tion Required %
Parrett	112	1943	160	---	0.0	0.0
Block & Rotstein	110	1943	100	4.0	---	0.0
Irving, Lippincott & Meyer	111	1943	218	2.3	---	13.3
Siever & Mousel	113	1943	300	1.0	---	0.0
Lull & Ullery	114	1944	50	0.0	---	0.0
Lull & Ullery	115	1944	112	0.9	---	0.0
McClellan & Williams	116	1944	100	0.0	---	0.0
Mengert	117	1944	200	1.0	9.5	3.5
Hingson & Edwards	118	1944	13350	1.5	---	0.6
Volpitto, Woodbury, Abreu & Torpin	119	1944	77	6.5	---	2.7
Nicodemus, Ritmiller & Ledden	120	1945	500	2.2	---	2.0
Total Cases Reported	---	---	15167	---	---	---
Average Incidence	---	---	---	1.5	5.3	0.8
Total Cases Considered in Averages	---	---	---	15007	360	15167

be a contributory factor in the production of asphyxia in the newborn. In a collected series of 1,951 instances of spinal anesthesia culled from the literature (Table IV), the uncorrected fetal mortality was 29, or a rate of 2.1 percent of 1,356 newborn infants; the incidence of delayed respirations in the newborn was 4, or 2.2 percent of 185 newborn infants; and the incidence of newborn infants requiring resuscitation was 24, or 1.2 percent of 1,951 newborn infants.^{94, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109}

Caudal and continuous caudal anesthetics also appear to exert a favorable influence upon the incidence of asphyxia neonatorum, again except when complicated by severe circulatory collapse.¹¹⁰ Irving, Lippincott and Meyer, in a series of 218 instances of continuous caudal anesthetics, found that they could correlate fetal distress and asphyxia with the occurrence of maternal hypotension.¹¹¹ In a series of 15,167 instances of the use of caudal anesthesia in obstetrical practice reported in the literature (Table V), the uncorrected fetal mortality was 221, or a rate of 1.5 percent of 15,007 newborn infants; the incidence of delayed respiratory activity in the newborn was 19, or 5.3 percent of 360 newborn infants; and the incidence of newborn infants requiring resuscitation was 127 or 0.8 percent of 15,167 newborn infants.^{110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120}

Those who claim no increase in the incidence of asphyxia neonatorum following the use of analgesics and anesthetics are guilty of either laxity or mendacity in their observations. The object of pregnancy is the production of a normal healthy infant.¹²¹ It is evident that both analgesia and anesthesia are produced for the mother at the hazard of asphyxiating her child.

THE CONDUCT OF LABOR WITHOUT
ANALGESICS AND ANESTHETICS

These statistics, which serve to demonstrate the role that may be played by obstetrical analgesia

and anesthesia in the production of asphyxia neonatorum, are thought-provoking to all physicians who deal with the parturient woman. Grantly Dick Read, by nature and by training a most thoughtful physician, came upon the obstetrical scene with the necessary background to ponder the mechanism of the pain of childbirth, and to develop an approach to the problem of the conduct of labor which renders the use of analgesics and anesthetics unnecessary in the majority of instances.¹²² His teachings, while as old as midwifery itself, have gained widespread recognition again only during recent years.^{123, 124} His method of control—or rather mental prophylaxis—of pain in childbirth is based upon the evil effects of fear on the woman during pregnancy and labor.¹²⁵ Apprehension usually lurks in the mind of the patient before conception even occurs, planted by the casual remarks of friends and relations, and altogether too often cultivated by the medical personnel in attendance during pregnancy and labor.¹²⁶ When the ordeal of labor begins, a vicious cycle is set up: fear begets tension, tension begets pain, and pain once more increases fear. For pain is brought to an awesome proximity through the telescope of fear.⁸⁷ To prevent this untoward sequence of events, Read advocated that the pregnant woman be coached repeatedly during pregnancy on her part in the job of conducting labor and delivery: muscular relaxation is taught systematically, for mental relaxation accompanies that of the muscles. When labor starts, the lessons learned in the previous months are put into application. The patient is kept in bed, for relaxation is most easily obtained in the recumbent position. She is heartened by the constant attendance and reassurances of her physician. As a result, the cervix relaxes and dilates in synergism with the uterine contractions, and the absence of tension minimizes the risk of lacerations of the soft parts. “No anesthetic is

accepted, when offered, by the majority of women so educated."¹²⁷

There is little doubt but that Read has done obstetrics two magnificent services: in an era when medication of the laboring woman has become so vigorous and so widespread as to be literally beyond the control of the physician, he has reminded the profession that labor can be normal, relatively painless, and even crowned with actual enjoyment; and he has re-emphasized the fact that provision must be made for the emotional and mental care of the obstetrical patient during pregnancy and labor.

THE PHARMACOLOGICAL PRINCIPLES GOVERNING THE USE OF ANALGESICS AND ANESTHETICS IN THE CONDUCT OF LABOR

Read has successfully eliminated two of the major etiological causes of asphyxia neonatorum, and it is deplorable that his techniques are unlikely to enjoy more widespread adoption. However, it may be that the method of Grantly Dick Read will prove to be a petard of sufficient violence to accomplish sobriety and intelligence in the use of obstetrical analgesics and anesthetics. For the fault lies not so much in the drugs as in their methods of application. Profitable amnesic, analgesic and anesthetic successes may be obtained for the parturient woman with the very drugs and methods that today are being interdicted against so strenuously. Such successes depend on zealous and meticulous adherence to the basic principles of pharmacological therapeutics. Obstetrical analgesics and anesthetics are sedative, hypnotic and narcotic agents of immense potency that pass the placental barrier freely, and their effects upon the fetus will be all too apparent even when their administration is cautious and well-supervised; certainly their effects upon the fetus may well become disastrous when they are employed with abandon in midwifery. A high incidence of fetal asphyxia, and fetal and even maternal deaths, will obtain until such time as obstetrical analgesia and anesthesia are practiced with moderation and strict adherence to the fundamentals of drug therapy.

Firstly, then, it becomes imperative to individualize the treatment of each laboring woman, and careful selection of both the agent and method is mandatory. It is distressing to find the terms "routine" and "always" rapidly becoming the hallmark of dissertations upon the subject of obstetrical analgesia and anesthesia. Only by individualization can the appropriate analgesic or anesthetic technique be selected.

Secondly, dosage must be chosen with zealous concern that it be the minimal effective dose necessary for that particular patient. A drug may be administered in order to achieve certain amnesic effects; when these ends have been achieved, it profits not to continue the administration of the same drug to the point where analgesia is

produced. Indeed, it is far more likely to be extremely dangerous to do so. In similar fashion, the dosage must not be so conservative that it sinks below the level of minimal effective dose to become the maximal ineffective dose. In the use of obstetrical amnesics, analgesics and anesthetics, as with all other forms of drug administration, the field of success is broad, but the hinterland of failure lies on all sides. Estimation of the proper dosage of a given drug to be employed in an individual patient is at best difficult, and often impossible: it requires tedious observation of the effects of each dose administered, adaptability in changing that dose when the necessity arises (as it surely will), and the astuteness to detect the earliest signs of toxicity or idiosyncrasy. Every physician adheres to such principles in the administration of digitalis to the cardiac patient; the time has arrived when he must also adhere to such principles in the administration of nembutal, demerol or ether to the parturient.

Thirdly, the physician must be in constant attendance to evaluate the effect upon the patient of the drug employed. All too commonly, in our lying-in units, medication is carried out by nurses either according to a fixed routine, or at the broad discretion of the nurse herself. It would seem that the constant attendance of a physician is not only ethically and legally imperative, but necessary for the proper administration of amnesics, analgesics and anesthetics.

Finally, cognizance must be taken of the fact that there may be other factors besides those of amnesia, analgesia and anesthesia tending to produce asphyxia neonatorum in a given patient. The complete syndrome of asphyxia neonatorum is usually the result of a combination of several of these factors rather than any given single factor in itself. The known presence of such factors demands moderation in the use of amnesics, analgesics and anesthetics.

Obstetrics has matured from midwifery, through the Age of Maternal Salvage, to the Age of Fetal Salvage. Only by the discriminate use of amnesics, analgesics and anesthetics can the Age of Fetal Salvage become a reality.

SUMMARY

1. The etiological factors of asphyxia neonatorum include the age of the mother, the parity of the mother, the health of the mother, the viability of the germ-plasm, the immaturity of the infant, the presentation and position of the fetus, the medical induction of labor, the duration and type of labor, the complications of labor, the type of delivery, the analgesic drugs employed, and the anesthetic agents and methods employed.

2. All forms of analgesia and anesthesia increase the incidence of resuscitation in the newborn infant, and therefore increase the incidence of asphyxia neonatorum.

3. Grantly Dick Read's method of the control of pain in childbirth by the suppression of fear permits the conduct of labor without recourse to the use of obstetrical analgesics and anesthetics.

4. For the sake of the infant, pharmacological principles must be scrupulously adhered to when analgesics and anesthetics are administered to the parturient woman. Each patient must be evaluated and treated on an individual basis. The dosage of the drug or drugs administered must be the minimal effective dose. The physician must be in constant attendance to evaluate the effects of the agents administered to the woman in labor. Cognizance must be taken of the presence of other factors, besides those of analgesia and anesthesia, that may tend to produce asphyxia neonatorum, and the use of analgesics and anesthetics must be modified accordingly. Modification of the regimen to suit individual needs requires application of broad knowledge, mature experience and the highest skills available in each community. Physicians must aim to meet the challenge.

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WHY MALARIA CURES GENERAL PARALYSIS

WALTER L. BRUETSCH, M.D.*

INDIANAPOLIS

This article was written in commemoration of the celebration on November 21, 1948, of the 100th anniversary of the Central State Hospital.

The Indianapolis institution has been frequently referred to as the home of the malaria treatment in the United States. The local hospital was first in establishing a service by which physicians throughout the country were able to obtain a certified strain of malaria for the treatment of general paralysis.

Through publications and particularly through the medium of scientific exhibits, which were shown at national and state medical meetings, the institution familiarized others with this mode of treatment. In this way many patients already suffering from general paralysis, but not receiving the proper treatment, were saved from dementia and death.

KNOWLEDGE of the curative principle of therapeutic malaria in the treatment of general paralysis is of more than academic interest. Any information which can be gained on this question will be of infinite value in the understanding of the pathogenesis of the disease itself, that is, why only a small percentage of all syphilitics develop general paralysis. It also will contribute to the solution of immunological problems in syphilis, which have puzzled investigators for many years.

IS INCREASED TEMPERATURE THE KILLING MECHANISM OF THE SPIROCHETES?

One explanation has been to ascribe the most important role to the high temperature, which is the outstanding clinical feature of malaria therapy. Certain investigators, led by Weichbrodt and Jahnel,¹ Schamberg and Rule,² Boak, Carpenter and Warren,³ Simpson,⁴ Bessemans,⁵ and others advanced experimental evidence that the *Treponema pallidum* was destroyed in local lesions and markedly inhibited in systemic syphilis by temperatures of 105.5° to 110° F.

There is, however, a large amount of evidence which disturbs the easy acceptance of the idea that spirochetes can be destroyed by fever in the human organism. For instance, Frazier,⁶ also found that body temperatures from 106° to 110° F. result in an inhibition of experimental syphilis, but at the same time he noted that temperatures ranging between 103° and 105° F. are without significant effect upon the spirochetes. For practical purposes this observation showed that temperatures which can be produced with safety in man are not deleterious to the syphilitic organism.

The finding of spirochetes (Figure 1) in the brains of unimproved general paralytics, who had eight to twelve malarial paroxysms, ranging be-

Figure 1

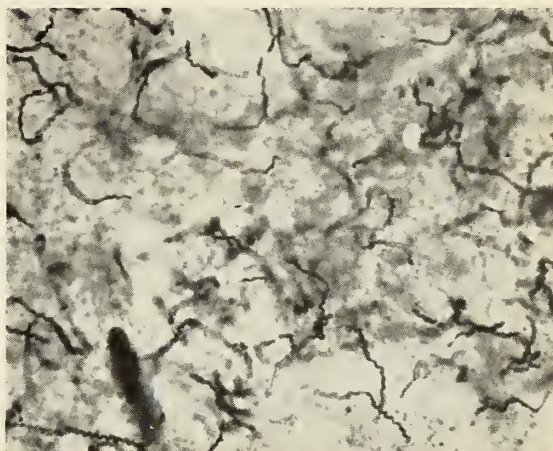


Fig. 1.—Numerous spirochetes in the brain cortex of a general paralytic patient, who died unimproved four years following malaria therapy. The thermal death time of *Treponema pallidum* in vitro has been given by Boak, Carpenter and Warren as five hours at 102.2°F.; three hours at 104°F.; and two hours at 105.8°F. This patient had many times these temperature requirements, yet masses of spirochetes persisted in the brain parenchyma.

tween 104° to 105° F., is convincing evidence that even the highest possible temperature which can be produced by malaria is not sufficient to sterilize the brain of the *spirocheta pallida*. The latter observation suggested that the *T. pallidum* may die in the test tube at 105° F., but in vivo will survive.

Schamberg⁷ expressed the view that the best results are obtained when the malaria fever is high, and that any infectious process which produces a high fever has virtually the same effect as malaria. But Kopp and Solomon,⁸ in a group of 182 patients with general paralysis to whom therapeutic fever in the form of malaria was

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Figure 2

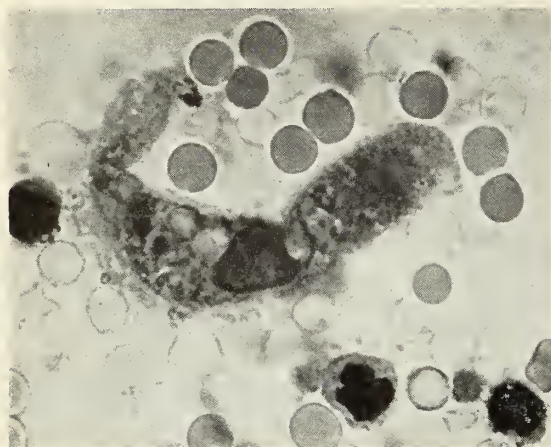


Fig. 2.—Early stage of stimulation of reticulo-endothelial cell (macrophage, histiocyte). The cell has still an elongated form. Smear, made from a hepatic vein of a general paralytic, who died after three malarial paroxysms, ranging between 102° and 103° F. Neutral-red stain.

Figure 3

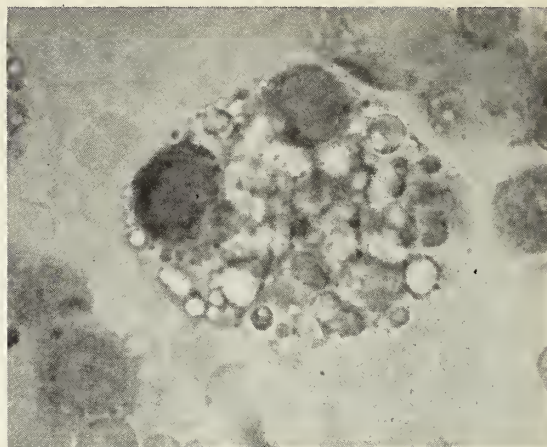


Fig. 3.—Advanced stage of stimulation of reticulo-endothelial cell. The cell (macrophage, histiocyte) has assumed a huge rounded form, contains numerous vacuoles and has phagocytosed two lymphocytes. Observed in the same smear. Neutral-red stain.

given, found that the maximum level of temperature appeared to be of no definite significance in producing better or poorer clinical results.

However, in my opinion, a high temperature is desirable because it is the expression of a high malarial parasite count,⁹⁻¹⁰ intensifying reticulo-endothelial stimulation. The longer and the more intense the malarial infection, the more noticeable is the increase in the number of macrophages.

Indeed, the very fact that general paralytics have been observed (Hermann, Wagner-Jauregg, Claude, Leroy, Medakovitch, Moore, Bahr and Bruetsch) who improved with little or no temperature at all should make one realize that some factors other than elevated temperature lie at the bottom of this treatment method.

No wonder that doubts greeted the introduction of artificial fever therapy because the "fever theory," if I may call it so, seemed entirely too simple for the explanation of the favorable results of malaria therapy. As a matter of fact, artificial fever did not seem to work too well in the hands of some investigators without the addition of tryparsamide.

On the other hand, Neymann and Osborne,^{11,12} and Bennett¹³ were enthusiastic, claiming superiority for artificial fever therapy.

Hinsie's and Blalock's results,¹⁴ however, were not as favorable, reporting only 17 percent full remissions. O'Leary¹⁵ also noticed a lower remission rate and a higher incidence of relapse in using artificial fever, when compared with malaria therapy. Confidence in the critical appreciation of these results was particularly weakened by the experience of Freeman, Fong and Rosenberg,¹⁶ who had not a single complete remission among 50 cases of general paralysis treated by diathermy. Moreover, in six cases in which death had occurred

from three to ten months following artificial fever therapy there was persistence of unusually marked perivascular infiltration in the brain. In the face of the statement by Doan¹⁷ that high temperature has a destructive effect upon lymphocytes, another conflicting point was added in the controversy of artificial fever versus malarial fever.

Unfortunately, the admirable studies of Barnacle, Ebaugh and Ewalt,¹⁸ using combined artificial hyperpyrexia and tryparsamide, cannot be used in this argument, since tryparsamide alone is known to benefit general paralysis in a considerable number of cases. Lorenz¹⁹ and his co-workers²⁰ obtained good clinical remissions in 41 to 54 percent of general paralytic patients who were treated with tryparsamide alone.

Another fact, which speaks against the assumption that fever alone will eradicate spirochetes, is the observation that when artificial heat alone¹² or malaria alone^{21, 22} was applied in early human syphilis, secondary cutaneous and mucous membrane recurrences occurred several months later.

A further serious challenge to the conventional theory on which artificial fever therapy is based comes from the demonstration by Ellingson and Clark²³ that hyperpyrexia causes a significant lowering of specific antibody titer in experimental animals. Previous to this work, there was a prevailing belief that fever is a wise provision of nature, increasing bodily defenses against invading micro-organisms. This idea has started a trend to use artificial fever in the treatment of several infectious diseases. The fact that artificial fever causes a reduction in the titer of all circulating antibodies should be taken into account in the use of this type of therapy.

In all fairness to the pioneers who were making honest attempts to replace malaria therapy, which

is by no means an ideal mode of treatment, (and which is now in the stage of being replaced by penicillin), it must be said that much conflicting evidence exists which makes it difficult to accept the statement that the common denominator of all the fever methods is increased body heat adversely affecting a thermolabile syphilitic organism.¹³

**MACROPHAGIC (HISTIOCYTIC) TISSUE REACTION
VERSUS HEAT AS THE MAJOR FACTOR IN
THE ELIMINATION OF T. PALLIDUM**

The mysterious "something" contained in malaria fever, and which is lacking in artificially produced fever, is the macrophagic cellular reaction both in the bloodstream and in the connective tissues throughout the body. Much laborious work on this question has convinced me that activation of the reticulo-endothelial system is caused by the plasmodia and by the debris of the red cells (Figures 2 and 3). Elevated temperature per se has nothing to do with this specific cellular reaction. This statement stands in contrast to Doan's experience,¹⁷ who claimed an increase in phagocytic cells in experimental animals, especially in the lymph nodes, spleen and liver, but curiously not in the bone marrow, from physical induction of artificial fever. A marked infiltration of polymorphonuclear leukocytes in the lymph nodes was also noted.

The artificial fever methods provoke mainly a polymorphonuclear leukocytosis,¹⁴ in contrast to malaria, which is attended by a macrophagic leukocytosis in the vessels of the internal organs. But it is the macrophagic group of cells, and not the polymorphonuclear leukocyte, which is important in the defense against syphilitic organisms.²⁴ Activation of the reticulo-endothelial cells as the principal factor in malaria therapy has been conceded by Cunningham,²⁵ Wagner-Jauregg,²⁶ Davidson,²⁷ and others. Cunningham²⁵ expressed himself as follows: "The use of malaria in the treatment of tertiary syphilis has been rationally explained by Bruetsch in terms of increased production and stimulation of tissue macrophages."

It has become a common belief that fever which accompanies infection is always associated with a stimulation of the reticulo-endothelial system. In my studies on the stimulation of the reticulo-endothelial cells by various infectious fevers, I have observed a great variation in the degree of this specific cellular reaction. Of the febrile diseases examined, malaria and typhoid fever produce the most intense macrophagic response. Next come the streptococci infections, in particular erysipelas. Subacute bacterial endocarditis has been said (Siegmund) to provoke a marked activation of the reticulo-endothelial cells (histiocytes), but the response is mild, when compared with malaria. Other fevers, such as acute rheumatic fever, show little histiocytic activation, the stimulation involving mostly the cells of the myeloid series.

The state of the reticulo-endothelial cells in cases dying from active pulmonary tuberculosis was also

studied. In some of these patients there was a daily rise in temperature between 102° and 104° F. for two months prior to death. In the vessels of the internal organs there were no blood histiocytes (macrophages), and the moderate increase of white cells consisted mostly of lymphocytes or monocytes. In the liver histiocytic stimulation was minimal. In the spleen there was a mild degree of chronic histiocytic activation, as evidenced by the presence of large macrophages.

In several untreated general paralytic patients, who had temperatures ranging from 102° to 105° F. several days before death, and who died of hypostatic congestion of the lungs or as the result of paralytic convulsions, there was a complete absence of reticulo-endothelial activation.

From these studies it became obvious that it is the kind of febrile disease and not the fever which determines the type and degree of the cellular response of the hemopoietic system.

In fact, little is known of the effect of artificially produced fever upon the reticulo-endothelial system. Schmid²⁸ noticed in rabbits, which were heated by diathermy, that the dye-storing capacity of the histiocytes and of the epithelial cells of the choroid plexus of the brain was increased. This phenomenon can be interpreted as a slight activation of these cells.

Since it is obvious by now that elevated temperature is not the killing mechanism of spirochetes, the question of the mode of their eradication from the paralytic brain following malaria therapy is of paramount importance. Earlier impressions suggested that increased phagocytosis of the malaria plasmodia was also directed against the spirochetes. This theory had to be discarded because no evidence of increased phagocytosis could be observed in the parenchyma of the brain, where the spirochetes are lodged.

Winkler-Junius²⁹ has submitted photomicrographs showing spirochetes within microglial rod cells and therefore assumed that these cells phagocyte and destroy the syphilitic organisms, which have penetrated into the nervous parenchyma. Merritt, Putnam and Campbell³⁰ have observed spirochetes within hypertrophied endothelial cells of the paralytic brain cortex. It may be mentioned here that spirochetes have also been seen within ganglion cells and glial elements. It is difficult in sections to decide whether a spirochete is actually within or just lying against a certain cell.

There is considerable evidence which mitigates the idea that phagocytosis is the mechanism by which the spirochetes are eliminated from the brain, although phagocytosis plays an important part in the control of the malarial infection. In supravital studies on the brains of patients who died during malaria treatment, it was found that the rod cells of the general paralytic cortex did not increase their phagocytic activity. In fact, malaria is not able to stimulate this microglial

element which has been identified as the phagocytic cell of the brain.³¹ Concerning the phagocytic properties of the capillary endothelial cells of the brain cortex, it could be shown that they did not become phagocytic for plasmodia as long as they retained their position in the capillary wall.³² From this one may conclude that phagocytic activity of the endothelium for *T. pallidum* is questionable.

These observations are in accordance with Chesney,³³ Zinsser,³⁴ and Kritschewski,³⁵ who believed that phagocytosis is not of major importance in the defense mechanism of syphilis. Levaditi³⁶ has observed in stained sections examples of what he regarded as phagocytosis of treponemes, but he did not notice phagocytosis in inoculating emulsions rich in spirochetes into the subarachnoid space of the rabbit. Yet the spirochetes disappeared rather quickly and completely. Nevertheless, the reservation should be made that in the organism which has been made immune or partly immune, phagocytosis may have a much more important part in the body defenses.

Since suppression of the spirochetes is not accomplished by phagocytosis, how then do the reticulo-endothelial cells eliminate the syphilitic organism? Phagocytosis is but one highly developed property of the cells of the reticulo-endothelial system. These cellular elements acquired renewed attention when Metchnikoff, Aschoff,³⁷ Gay,³⁸ Jaffé,³⁹ Sabin,⁴⁰ demonstrated their relationship to antibody formation. In the earlier years immunity was chiefly thought of in terms of phagocytosis. Cessation of growth and disintegration of bacilli outside of the phagocytic cells is common in the body with acquired resistance.

The killing mechanism of the spirochetes in general paralysis, therefore, must be looked for in antibody production by the reticulo-endothelial cells.

The spirochetal immune body appears to be of a group character, and malaria produces an increase of this spirochetal complement-fixing antibody.⁴¹

The bone marrow, spleen and liver have been mentioned as the predominating organs of antibody production. The macrophages, which are formed by malaria therapy in such large numbers, particularly in the liver, spleen and bone marrow, produce antispochetal immune substances, which are instrumental in the destruction of the spirochetes. In general paralysis, the participation of this humoral phase is most likely because of the difficulties of producing macrophages in the regions where the spirochetes are located, namely in the brain parenchyma. Yet the spirochetes disappear in the months following malaria therapy without any additional drug treatment. The brain in general, but particularly in dementia paralytica, does not produce immune bodies to any great degree and therefore is dependent upon the immune body production in other organs. This very fact seems to be indirect evidence of

the participation of humoral bacteriostatic substances in the mechanism of malaria therapy.

It has been said that the bactericidal properties of the fluids of the immune body may be operative *in vivo* even though they cannot be demonstrated *in vitro*, and that the immune body has undergone some more subtle changes which render it less favorable as a medium for the growth of bacteria.⁴² This explains possibly the negative results of Beck,⁴³ who examined the behavior of spirochetes *in vitro* as to immobilization and eventual agglutination in the presence of serum and cerebrospinal fluid from general paralytic patients who had been treated with malaria. Caldwell,⁴⁴ on the other hand, found that malaria treated sera possessed treponemicidal properties, their spirocheticidal strength depending on the time that has elapsed since the termination of malaria.

The process of formation of antibodies by the reticulo-endothelial cells takes place in three stages.⁴⁰ Time is of prime importance for the consummation of these processes. The importance of the Time Factor is shown in the behavior of the serologic reactions. In the first two years following malaria therapy, there is little change toward negativity in the Wassermann reaction of the blood and spinal fluid. But in the following years the number of improved and totally negative Wassermann reactions increases from year to year, so that three to four years after malaria therapy about 60 to 70 percent have a completely negative Wassermann.⁴⁵⁻⁴⁶ Similar percentages were observed in the Indianapolis cases of general paralysis, which had received no other treatment than malaria. This long continued beneficial after-effect is one of the most remarkable features of malaria treatment which sets this therapy apart from other nonspecific therapies of syphilis.

In addition to the stimulation and new formation of the macrophages, accompanied by antibody production, the reactive changes on the endothelial cells of the brain capillaries play a role in the mode of action of malaria therapy. The stimulation of the endothelial cells of the capillaries of the brain cortex and of the meninges is considered responsible for the varied degrees of permeability during and after malaria treatment.⁴⁷⁻⁴⁸

One of the important features of the pathophysiology of general paralysis is the increased permeability of the capillary network of the brain parenchyma.⁴⁹ Due to the stimulating effect of the plasmodia, the already increased permeability of the cortical vessels becomes more pronounced during malaria treatment. This observation is in accordance with views established by physiologists (Ebbecke), namely, that stimulation of endothelial cells and increase in permeability parallel each other. Following malaria treatment, the increased permeability is gradually reduced and becomes normal in those patients who respond well to the treat-

ment. This subsequent reduction of the permeability is explained by the fact that endothelial stimulation is associated with a reversible increase in cell permeability,⁵⁰ and furthermore, that as a result of a previous stimulation of extraordinary magnitude the reduction in permeability becomes more pronounced.⁵¹ Endothelial stimulation of the capillaries of the brain cortex by the malaria plasmodia and, in addition, by the debris of the red corpuscles is thought to be one of the more important phases of the therapeutic effect of the malaria treatment of general paralysis.

CAN GENERAL PARALYSIS BE CURED BY MALARIA ALONE?

The all important question may now be asked: Can general paralysis be cured with malaria therapy alone? Observations made over the last 23 years at the Central State Hospital of Indianapolis answer this question in the affirmative. If a reversal of all the serologic reactions has been obtained, the cure is permanent and a relapse does not occur.

Malaria supplies only the necessary stimulus to the mechanism by which immunity is finally obtained. Individuals vary greatly in their defensive powers, and therefore this type of therapy cannot be expected to be curative in all cases. For this reason one sees patients in whom a few malarial paroxysms will lead to complete cure. On the other extreme are instances where the best course of malarial fever will not stimulate the reticulo-endothelial system sufficiently, and the paralytic brain process remains unaffected.

HOW DOES THE POSITIVE WASSERMANN REACTION BECOME NEGATIVE?

The investigations on the *modus operandi* of malaria therapy in general paralysis have also some bearing on the solution of unsolved questions in syphilis in general. One of these is the mechanism by which the positive Wassermann reaction may become negative.

It has been stated by Matuschka and Rosner⁵² that in the past, with intensive routine anti-syphilitic treatment, it was possible to obtain a negative Wassermann of the blood in only about 7 percent of patients with an old and neglected syphilis. With the additional use of malaria therapy, the positive blood serology reverted to negativity in 61 percent of these patients. It is most likely that the macrophagic reaction, which is provoked by malaria treatment, is responsible for this result.

Bone marrow examinations, which were correlated with serologic studies on general paralytic patients who died at various intervals following malaria therapy, revealed that the large number of macrophages, which were produced during acute malaria, could be observed from five to seven and

occasionally for more years afterwards. Their presence over such long periods, attended by the production of immune bodies, has been thought to be responsible for the slow but persistent changes toward negativity of the serologic reactions in malaria-treated syphilitic persons.

CONCLUSIONS

Summarizing the situation, then, one may say that elevated temperature is only a minor factor of a number of highly complicated and separate phases which make up the mode of action of malaria therapy. The principal factor is activation of the reticulo-endothelial system, expressing itself in the production and stimulation of macrophages. As the result of this stimulus to the reticulo-endothelial cells there is the development of immune reactions. The enhanced tissue immunity inhibits the growth of the spirochetes which finally disintegrate and disappear from the tissue. This is followed by a regression and complete resolution of the inflammatory process which is the major characteristic of the general paralytic brain process.

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TREATMENT OF SUPRACONDYLAR FRACTURE OF THE HUMERUS

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GARY

WITH present-day equipment, materials, medicine, and the art of skilled surgery, fractures in general can be and are treated with better results and far less deformity and disability than at any time in the past. Of all the fractures of the upper extremity, none warrants more frequent attention than the common supracondylar fracture of the humerus. This fracture is more prevalent among children than adults. The cause of these fractures in adults and children is somewhat different. Although treatment basically is alike in the adult and child, the final result may be different, as one may observe later in this paper. In general, the supracondylar fracture is recognized as a serious lesion, both from the standpoint of difficulty in reduction and fixation and because of the accompanying soft tissue damage.

ETIOLOGY

The supracondylar fracture may be caused by direct or indirect violence. Direct crushing by moving machinery is not an infrequent cause of these fractures, and for this reason they are frequently compound, with much soft tissue damage. Workers, such as bridgemen, painters and construction workers, falling from heights and landing on their hands and elbows, frequently suffer this lesion. As a rule, however, adults rarely fracture their elbows from simple falls on the hands, as do children, who most frequently break their elbows in this manner. Elbow fractures in children differ from those in adults, in that they tend to follow the epiphyseal lines. Compound fractures are rare in children except when there may be a direct injury, or when in an indirect injury, such as falling on the hand, the lower end of the shaft (Fig. 7) passes through the anterior or lateral borders of the skin just above the elbow.

PATHOLOGY

It is imperative that one understand the contour of the lower end of the humerus in order to reduce fractures properly in this area. The flattened-out portion of the humerus immediately above the condyles is the area through which the fracture plane passes. Most commonly the fracture plane passes through the flattened portion of the shaft at an oblique angle in which the posterior fracture line is proximal to that of the anterior fracture line. This forms a path on which the distal fragment slides upward and backward, in the presence of trauma, with the arm extended. Rarely is this

fracture plane reversed, in which case the distal fragment is displaced forward and upward. When the lower fragment is pushed upward and backward, the triceps, brachialis anticus and biceps muscles help pull and hold the distal fragment and forearm upward. With the forearm fully extended the lower fragment is held in flexion by the muscle attached to the epicondyles. The lower fragment may be freely moved laterally and medially; it is almost always turned inward (Fig. 1, Fig. 4 and Fig. 7) and follows the movement of the forearm. The shaft through the rotator shoulder muscles and the inertia of the forearm is turned outward on its long axis. In very young children, from one to three years of age, one must bear in mind that the cartilaginous epiphysis at the lower end of the humerus may be displaced *en masse*. Rarely may a fracture extend through the olecranon fossa below the condyles.

The sharp edge of the lower end of the shaft (Fig. 1, Fig. 4, Fig. 7, Fig. 11) can frequently be palpated above the elbow. The sharp edge of this bone is responsible for lacerations of the brachial artery, nerves and muscles. Rarely in children and more commonly in adults, the distal fragment may be split in two in "T" fashion and the lower end of the shaft wedges between the distal fragments (Fig. 13 and Fig. 17), accounting for a much widened elbow joint. Periosteal ripping of the shaft may account for an increased callus formation under it, frequently impairing good functional recovery. Occasionally one may see a green stick fracture in children and these fractures usually are easily reduced and cause little or no impairment of function.

CLINICAL FINDINGS

There usually is pain, swelling, deformity, abnormal mobility and crepitation. There is usually a marked backward displacement of the elbow with an absence of a hollow space above the olecranon. Supracondylar fractures are found close above the condyles and the forearm moves with the condyles and olecranon. The condyles and olecranon have their normal relationship. The forearm can be extended and appears longer. Flexion of the forearm and elbow is impaired due to obstruction of the lower end of the shaft on the forearm bones (Fig. 1, Fig. 7). The lower end of the shaft may be felt above the olecranon, and in this case there will be marked impairment of extension and little disturbance of flexion of the elbow. Compound fractures may reveal severe damage to both bone and soft tissue.

Fig. 1



Fig. 1, Case 1. Reveals supracondylar fracture with marked posterior displacement of distal fragment in child aged eight.

Fig. 2

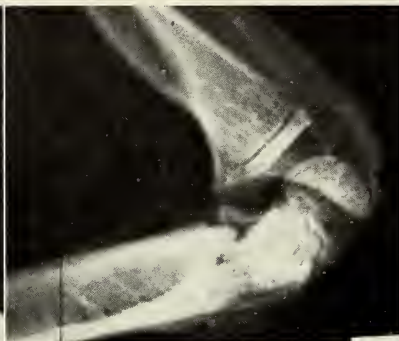


Fig. 2, Case 1. Shows lateral view with good position following closed reduction.

Fig. 3

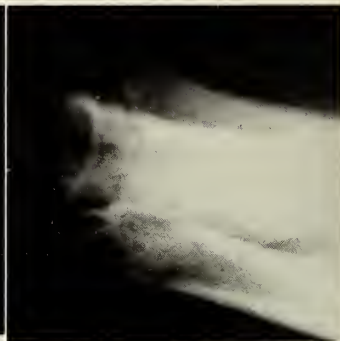


Fig. 3, Case 1. Shows anteroposterior view of same case.

NERVE INJURY

One should make it a point to test the functions of the radial, medial and ulnar nerves before attempting treatment or reduction in these cases. The nerves may be injured or severed directly from the trauma, or they may be caught between the fragments and injured during the manipulation. In all simple fracture cases it is best to defer any immediate treatment as the function in nearly all of these cases is regained completely in due time. When there is a marked compound fracture which warrants an exploration, severed nerves should be sutured immediately.

BLOOD VESSEL INJURY

Injury to the brachial artery frequently occurs when there is marked displacement of the distal fragment. The sharp edge of the lower end of the shaft works itself anteriorly toward the tightened skin surface and brachial artery. Sometimes it tears a small hole in the artery and at other times it may traumatize the artery sufficiently to cause a thrombosis and impairment of circulation to the forearm and hand. Sometimes, even with a severed and ligated brachial artery, there is sufficient collateral circulation not to cause gangrene of the

forearm. Any tear and bleeding of the artery causes great swelling with loss of the radial pulse. It is best in these cases to defer treatment by placing the arm in extension and waiting for four to six days, for the swelling to subside, before completing reduction.

DIAGNOSIS

One may find a simple fracture with little or no evident posterior displacement of the distal fragment or there may be a marked posterior displacement of the elbow and forearm, in which case there is no disturbance of the normal relationship of the condyles and olecranon. There is preternatural mobility laterally above the condyles which is evident only in supracondylar fractures. There is full extension with marked limitation of flexion of the elbow. In comminuted or in "T" fractures the lower end of the shaft may be felt above the olecranon where it may cause the distal fragments to lie apart. X-ray findings definitely establish the diagnosis.

DIFFERENTIAL DIAGNOSIS

In dislocation of the elbow the distance from the internal condyle to the styloid is shortened, while in supracondylar fractures it is normal. In

Fig. 4

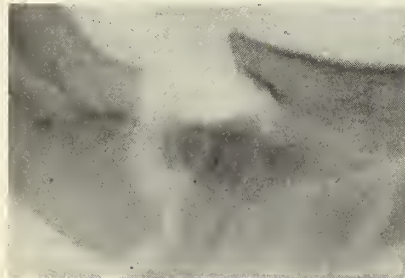


Fig. 4, Case 2. Reveals supracondylar fracture with marked posterior displacement and inward rotation distal fragment in child aged four.

Fig. 5

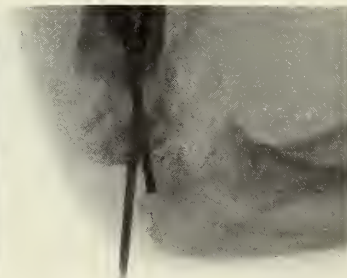


Fig. 5, Case 2. Reveals lateral view following open reduction and fixation with stainless steel wires.

Fig. 6

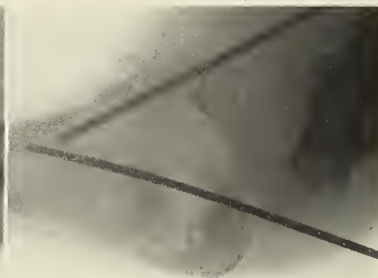


Fig. 6, Case 2. Same case showing good position in anteroposterior view.

Fig. 7

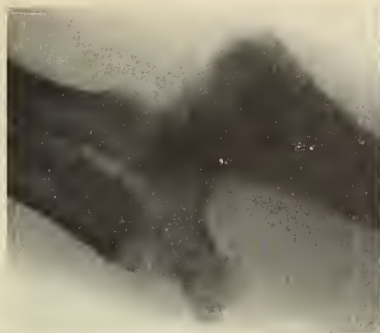


Fig. 7, Case 3. Reveals supracondylar fracture with marked displacement and internal rotation distal fragment in child aged nine.

Fig. 8

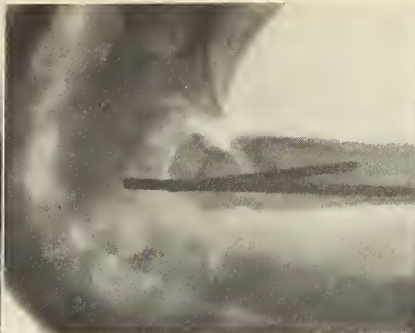


Fig. 8, Case 3. Reveals lateral view following open reduction and metal fixation.

Fig. 9



Fig. 9, Case 3. Same case showing good position in anteroposterior view.

dislocation there is a hollow space immediately above the olecranon. In external and internal condyle fractures the findings are limited to the small area involved, with no deformity of the vertical axis of the arm, and there is no lateral play present.

CLOSED REDUCTION TREATMENT

Whenever possible the supracondylar fracture of the humerus should be reduced under general anesthesia, and as soon as possible after the accident, to release any undue pressure on nerves and blood vessels. There is less swelling and the landmarks are easily recognized. Closed manipulation and reduction is done by carefully and fully rotating the arm and forearm outward, and then with the whole arm at a right angle to the body, the extended forearm in supination is moved from extension to a flexed position with the long axis of the arm. The posteriorly displaced distal fragment is forced with digital pressure over the end of the shaft. If reduction is complete there will be no bony obstruction noted in acute flexion of the elbow. Acute flexion locks the lower fragment and it is held there by the triceps muscle. Fol-

lowing this maneuver, with one hand holding the lower fragment in position, the forearm should be fully extended for a checkup and then placed back in acute flexion. The radial pulse should be tested at this point. X-ray in anteroposterior and lateral views should be taken at this time and after the cast is applied.

Only a posterior plaster of paris molded splint should be used, extending from below the shoulder to the wrist joint. When the swelling is marked the forearm should be splinted in a less acute angle to a right angle. Sometimes it is best to defer treatment for a few days when the swelling is very marked. The radial pulse in splinted cases should be watched carefully for the first thirty-six hours.

It may be necessary to decrease the angulation of the elbow from the more acute to a right angle position four to twelve hours after reduction, even with the possibility of dislocating a good reduction to prevent Volkmann's ischemia. Second manipulation and reduction can be completed two to four days later, with subsidence of swelling and recurrence of good radial pulse. Tight band-

Fig. 10



Fig. 10, Case 4. Reveals severe comminuted supracondylar fracture with marked posterior displacement of distal fragment in child aged nine.

Fig. 11



Fig. 11, Case 4. Reveals same case in lateral view.

Fig. 12



Fig. 12, Case 4. Reveals lateral view of same case with good functional alignment following open reduction and metal fixation.

Fig. 13



Fig. 14

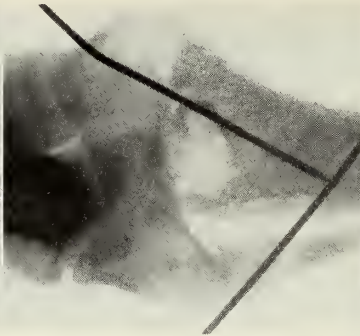


Fig. 15

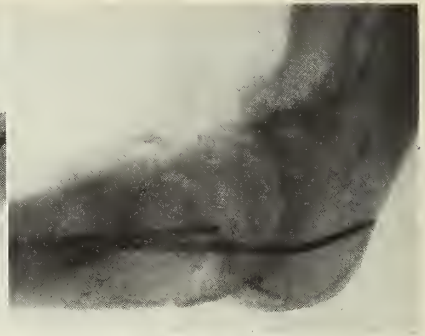


Fig. 13, Case 5. Reveals compound comminuted "T" fracture of supracondylar area in adult aged 67.

Fig. 14, Case 5. Reveals same case in anteroposterior view following open reduction and metal fixation.

Fig. 15, Case 5. Shows same case in lateral view.

Fig. 16, Case 5. Shows same case one year after injury.

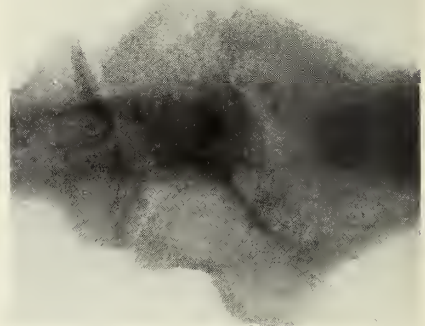


Fig. 16

ages should be cut and loosened to allow for extra expansion of the swelling. Swelling is greatest the first eight hours, with some increase in the following twelve to sixteen hours. Swelling of the hands and tightness of the skin of the fingers may be an early sign of impaired circulation, though not necessarily so. One cannot stress too often the importance of preventing Volkmann's contracture. When the lower fragment is displaced forward manipulation and reduction is reversed to that of the posterior dislocated type. Because of the nature of the angle the fracture is best held with the elbow at a right angle and sometimes at a straight angle.

The elbow is left in the cast from two and a half to four weeks in children, and from four to six weeks in adults before physiotherapy treatment is started. Early forceful passive motion is discouraged.

OPEN REDUCTION TREATMENT

Closed reduction and conservatism is the treatment of choice in supracondylar fracture of the humerus but there are cases in both children and adults which will not respond to this type of treatment. In this event surgery is justifiable and necessary. The technique and fixation method used for the past ten years by the author is a relatively easy way of holding a difficult fracture in good position. A longitudinal incision three to four inches long is made in the posterior midline of the elbow joint. The skin is freed to either side as far as the epicondyles. After due blunt dis-

section of muscles, the lower end of the shaft and the fracture site is exposed, following which reduction of the fracture is completed and fixation is maintained by inserting by means of an electric drill two stainless steel or Kirchner wires $\frac{1}{8}$ to $\frac{3}{8}$ of an inch in diameter (Fig. 19). One wire is passed from the external epicondyle upward and inward into and across the shaft and through the cortex on the medial side of the shaft of the humerus. The second wire is inserted through the medial epicondyle (care being taken not to injure the ulnar nerve), upward and outward across the flattened shaft, and through the cortex on the opposite side. During the above maneuver an assistant holds the elbow and fragment in the desired position. Each wire is just barely run through the cortex while the ends at the epicondyles are cut off by means of a wire cutter, to leave one-half inch protruding through a small puncture of the skin to permit their removal at a later date. X-rays are taken before closure to assure good reduction. Following closure of the wound, a posterior plaster of paris molded splint is applied, with the forearm in acute flexion. The radial pulse is checked in the usual manner. The cast is removed on the seventh postoperative day, when the stitches are removed and the elbow is lightly manipulated in flexion and extension. The wires are removed in two to four weeks, depending on the age of the patient. Occasionally, one may use a Sherman stainless steel transfixation screw in a supracondylar "T" fracture, as shown in Fig. 18.

Fig. 17



Fig. 17. Case 6. Reveals compound comminuted "T" fracture of supracondylar area in adult aged 55.

Fig. 18



Fig. 18. Case 6. Shows same case one year later with metal screw fixation.

Supplementary introduction of chemotherapeutic agents, such as sulfonamides and penicillin, are administered according to the necessity of each specific case. In local topical therapy, in open compound wounds, 0.5 percent Dakins solution is the treatment of choice.

RESULTS

In children, with good reduction there is no tendency to permanent stiffness or ankylosis. The child will develop all motions permitted by the position of the fragments. One must practice great care to avoid inward rotation of the distal fragment as this may eventually cause cubitus varus or "gunstock" deformity. A good functional recovery in an adult will depend on the accuracy of reduction, early motion and not too long fixation and splinting. With bad, comminuted or "T" fractures the prognosis is less good, from marked limitation of flexion and extension to complete ankylosis of the elbow.

DEMONSTRATION OF SLIDES AND CASES

Case 1. Patient was a child eight years of age, who fell on outstretched hand and received a simple supracondylar fracture with marked posterior dislocation. (Fig. 1.) The fracture was reduced by closed reduction (Fig. 2 and Fig. 3) and posterior plaster of paris splint was applied. Splint was removed in three weeks. Had full functional motion of elbow in ten weeks.

Case 2. Patient was a child four years of age, who received a simple supracondylar fracture (Fig. 4) from a fall down stairs. Closed reduction was done, but because of severe swelling and impairment of circulation to the hand, the forearm had to be let down to a straight angle before a radial pulse could be obtained. Three days later a second closed reduction was attempted but since it was not successful, an open reduction was done and two stainless steel wires were inserted (Fig. 5, and Fig. 6). In Fig. 5 may be noted a marked compression fracture of the posterior border of the distal fragment. The wires were removed in three weeks and the cast in four weeks. The child

had practically full motion of the elbow in three months.

Case 3. This child, nine years of age, fell off a bicycle and received a compound supracondylar fracture (Fig. 7), which could not be held by closed reduction. Three days later an open reduction was done and two stainless steel wires were inserted (Fig. 8 and Fig. 9). The wires were removed in three weeks and the cast in four weeks. Six weeks later, the child had moderate limitation

Fig. 19

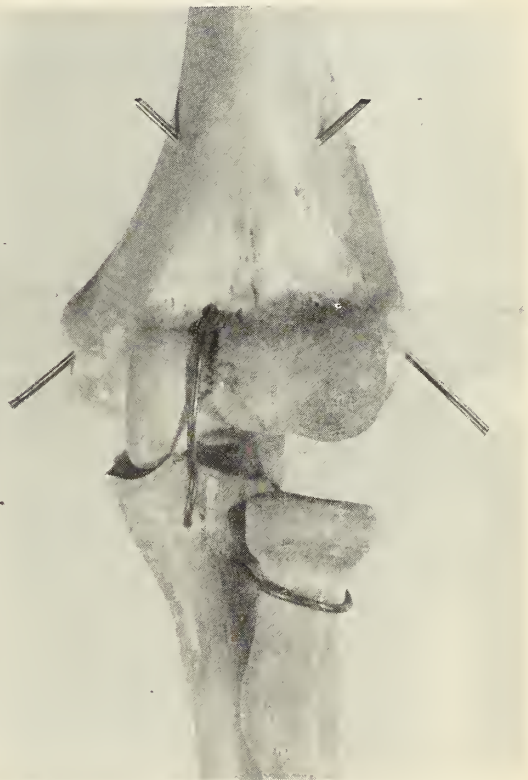


Fig. 19. Reveals skeleton of elbow and desired route and direction of stainless steel wires in presence of supracondylar fracture of humerus.

of flexion and extension, but the eventual result should be very good with nearly full motion.

Case 4. This was a child nine years of age, who received a severe comminuted supracondylar fracture (Fig. 10 and Fig. 11). Closed reduction was not satisfactory and so an open reduction was done immediately. The fracture was held in good functional position by means of one stainless steel wire (Fig. 12). The child had an uneventful recovery with practically full flexion and full extension of the elbow.

Case 5. This patient was an adult, sixty-seven years of age, who received a compound comminuted "T" fracture of the supracondylar area (Fig. 13) when his elbow was caught in moving machinery. He was immediately operated on, at which time two stainless steel wires were inserted (Fig. 14 and Fig. 15). One year later (Fig. 16) the patient had about 40 percent impairment flexion and extension of the same elbow.

Case 6. This demonstrates another compound comminuted "T" fracture of the supracondylar

area (Fig. 17), an adult aged fifty-five who injured his elbow in a high fall. In this case one long stainless steel Sherman transfixation screw was used (Fig. 18). After one year the patient had only 50 percent impairment of flexion and extension of the injured elbow.

CONCLUSION

It is necessary to understand the mechanism and anatomical relationship which make up the deformity in order to treat properly and reduce supracondylar fractures of the humerus. One must manage each case accordingly, depending on the individual condition. Conservative closed reduction is preferable. A simple, effective and long tried operative fixation treatment with stainless steel wires has been described.

Vigilant checking of the radial pulse is the best guide to prevent complication of Volkmann's ischemia. Progress is usually very slow as to recovery of full motion of the elbow, but the eventual end result is good when reduction is good.

THE ELECTROCARDIOGRAM IN ACUTE PERICARDITIS:

A COMPARISON OF CASES WITH AND WITHOUT EFFUSION INTO THE PERICARDIAL SAC

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DURING a recent study of cases of acute pericarditis in an Army General Hospital, it was noted that in many instances roentgenograms of the chest had been taken sufficiently often that the course of effusion into the pericardial sac could be followed graphically, or that the absence of effusion during the course of the disease could be established beyond a reasonable doubt. The following is an attempt to correlate the degree and duration of pericardial effusion, or its absence, with the patterns of the electrocardiograms taken during the course of the disease in twenty-four cases.

Several excellent reviews of the literature pertinent to this subject have been made. Among the more recent is that of Noth and Barnes,¹ and since another review would be repetitious, the interested reader is referred to this article.

MATERIAL

Twenty-four cases of acute pericarditis have been studied and have been divided into two groups. Group I includes sixteen patients in whom pericardial effusion was thought to be present. Group II is comprised of eight patients in whom pericardial effusion was thought to be absent.

The patients were male soldiers whose ages varied from 18 to 34 years. Twenty-two patients were in the third decade of life. The average age of the entire group was 24.5 years. All of the patients recovered. The criteria for selection of cases were: (1) An unequivocal diagnosis of pericarditis. (2) Sufficient roentgenograms of the chest and electrocardiograms to allow careful comparison of the two during the course of the disease. (3) The exclusion beyond a reasonable doubt of associated disease of the myocardium, such as myocardial infarction, as a factor in the production of the electrocardiographic abnormalities.

A diagnosis of acute pericarditis was made when the patient complained of pain in the precordium, frequently severe and of sudden onset and usually accompanied by pain on breathing, on swallowing, on rotation of the trunk, and by exaggeration of the pain when the patient was in the supine position. Objectively, clinical signs and roentgenograms suggestive of pericardial effusion, or a pericardial friction rub, or both, were present. In all cases, electrocardiographic abnormalities of the type characteristic or highly suggestive of acute pericarditis were noted.

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It is felt that myocardial infarction can be excluded as a causative factor in the illnesses of these patients because of the following reasons: (1) None of the patients gave histories suggestive of myocardial ischemia prior to or subsequent to their illnesses. (2) Electrocardiographic patterns suggestive of myocardial ischemia or infarction were not encountered. (3) With one exception, the patients were 29 years of age or younger. In this age group, myocardial infarction is rare. The patient who was thirty-four years of age had acute pericarditis complicating an attack of acute glomerulonephritis.

Thirteen of the instances of acute pericarditis complicated an attack of acute rheumatic fever. In eight cases pericarditis was of indeterminate etiology, so-called idiopathic pericarditis. Of the three remaining cases, one occurred during an attack of acute glomerulonephritis, one followed nonpenetrating trauma to the chest, and in one case pericardial effusion accompanied bilateral pleural effusion (polyserositis).

In all instances, the roentgenograms were carefully reviewed. The problem of differentiation between pericardial effusion and cardiac dilatation was carefully considered, and cases were not included in which there was a reasonable doubt as to which factor was responsible for enlargement of the cardiac silhouette. Points of differentiation in favor of effusion were: (1) Loss of the normal cardiac contour and chamber markings; (2) Obliteration of the posterior cardiophrenic angle in lateral views; (3) Rapid change in the size of the cardiac silhouette, and (4) The absence of markings in the lungs suggesting pulmonary congestion. It is admitted that differentiation is difficult and may be impossible in some instances. However, a vigorous effort was made to reduce errors to a minimum.

The electrocardiograms in all instances included the standard limb leads and lead IVF.

DATA

Group I. Patients with Effusion into Pericardial Sac.

Sixteen patients whose ages varied from 18 to 34 years (average 23.4) comprised this group. In eight of the patients pericarditis occurred during the course of an attack of acute rheumatic fever. Five patients suffered from idiopathic pericarditis and in the remaining three instances pericarditis occurred once each in conjunction with the following conditions: acute glomerulonephritis, nonpenetrating trauma of the chest, and polyserositis. A total of 87 (average 5.4) roentgenograms of the chests of these patients were taken. Only those roentgenograms taken during the period from the beginning of the illness until the disappearance of the effusion or until the electrocardiogram returned to normal were included. Thus this figure is not weighted by numerous normal roentgenograms taken during the patients' hospital tenure. The degree of effusion was expressed numerically by grading on a basis of I to IV, in which I indicates the least amount and IV the maximum amount of effusion. It was found that the maximum effusion in individual

cases was graded IV in one case, III in 6 cases, II in 8 cases, and I in one case.

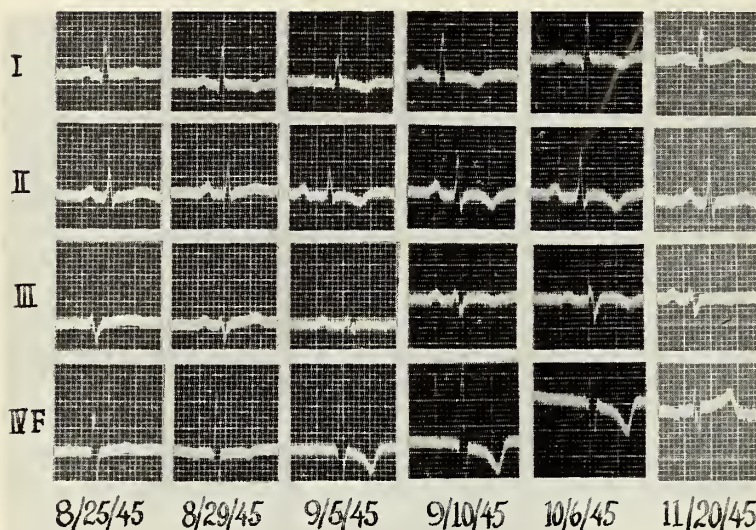
Pericardial effusion was noted in the first roentgenogram taken in 14 cases, the roentgenograms having been taken during the first nine days of the disease. In two instances when roentgenograms were taken on the first day of illness, normal cardiac shadows were noted and effusion developed subsequently. The maximum degree of effusion in individual cases was reached in the first week of the illness in seven cases. In eight cases the maximum degree of effusion was reached in the second or third week of illness, and in one case the maximum was not reached until the fifth week. Some degree of effusion was present for periods varying from two to twelve weeks, but in twelve instances was present for only two to four weeks. The duration of effusion in the remaining cases was five weeks in two cases, six weeks in one case, and twelve weeks in one case.

Electrocardiograms studied included those taken from the time of onset of pericarditis until the first normal tracing was obtained. A total of 133 (average 8.3) electrocardiograms were reviewed. Cases were not included in which electrocardiograms had been taken less frequently than once weekly, except that in a few instances the initial electrocardiogram had not been obtained until the second week of the illness.

Among these patients electrocardiographic abnormalities were diagnostic or highly suggestive of pericarditis. Significant elevation of ST segments was noted in eight instances in which electrocardiograms were taken during the first few days of the illness. In the remaining eight patients the first electrocardiograms were taken on the sixth to fourteenth day of illness, and the ST segments were isoelectric, but T wave negativity in one or more leads had occurred. In all cases in which ST segment deviation occurred, the deviation was an elevation. Leads I and II were involved in four cases and the following combinations of leads were involved once each: Leads I and IVF, Leads II and III, Leads I, II and IVF, and Leads I, II, III and IVF. Segmental elevation was present in a single electrocardiogram in four cases, in two electrocardiograms in three cases, and in three electrocardiograms in one case. In the cases in which deviation was present in more than one electrocardiogram, tracings had been taken at intervals of one to three days during the first week of the disease. Elevation of segments was not observed to persist longer than six days in any individual case. Reciprocal deviation of ST segments was not present in the electrocardiograms studied. In the instances in which segmental elevation occurred, the segments, with one exception, returned to the isoelectric level before T wave negativity occurred. In the exception noted, T_i was shallowly inverted when ST_i was 1 mm. above the isoelectric level.

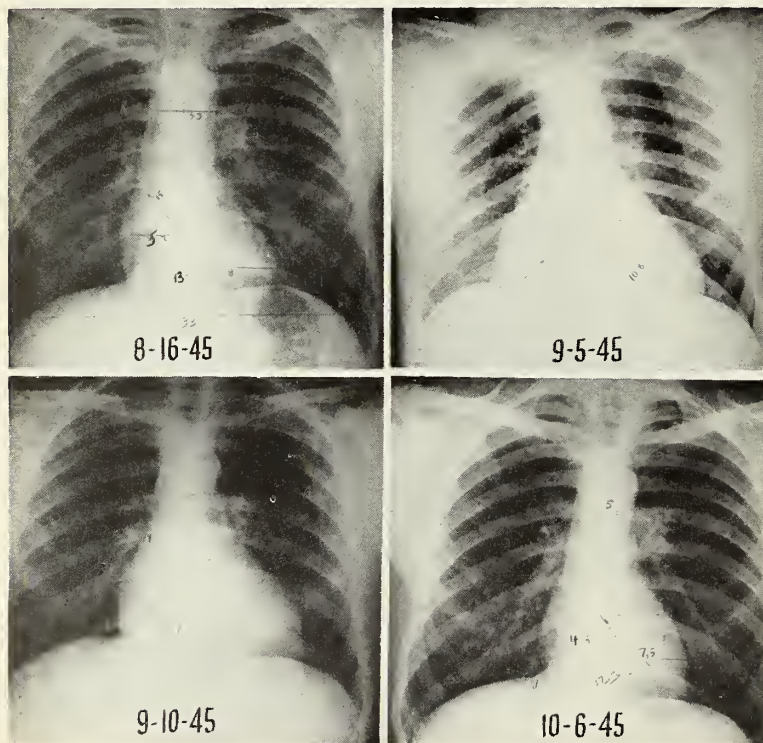
In the group as a whole T wave abnormalities developed in from two to thirty days following onset of symptoms. In thirteen cases, however, T wave

Figure 1



Case 9. Onset of pericarditis of idiopathic origin August 15, 1945. First electrocardiogram taken August 25, 1945, reveals low voltage of T waves. Subsequently, T waves in all leads became inverted. The electrocardiogram dated November 20, 1945, is normal. In lead II of the electrocardiogram dated September 5, the PR interval is apparently 0.24 seconds. However, this is thought to be due to the isoelectric onset of the QRS complex in this lead as a result of a small Q_1 and R_2 . In Figure 2 are illustrated roentgenograms of the chest taken at intervals during the patient's illness.

Figure 2



Case 9. Onset of pericarditis August 15, 1945. Maximum effusion in this patient is represented in the roentgenogram of September 5, 1945. The electrocardiograms illustrated in Figure 1 were obtained from this patient.

abnormalities developed between the sixth and seventeenth days. Frequently in individual cases the T waves were noted to be of low voltage at the onset of pericarditis, then isoelectric, and finally inverted. In all cases abnormalities of the T wave were striking and similar. With three exceptions, serial electrocardiograms exhibited negativity of T waves, or T waves were diphasic in each of the standard limb leads and in Lead IVF. In four cases T wave negativity was present in all leads simultaneously. In eight additional cases, T waves in all leads were inverted, diphasic, or isoelectric simultaneously. In the remaining cases T wave negativity was present in three leads twice, and in two leads in one case. T wave abnormalities were present for a period of two to sixteen weeks, but varied from two to six weeks in twelve cases. The abnormalities persisted for nine weeks in two cases, for twelve weeks in one case, and for sixteen weeks in the remaining case.

The duration of electrocardiographic abnormalities, including both segmental deviation and T wave reversal, varied from three to sixteen weeks, but in fourteen cases was from three to nine weeks.

In Figure 1 there are reproduced some of the serial electrocardiograms of case 9. Roentgenograms of the chest of this patient are pictured in Figure 2. In this case a moderate degree of pericardial effusion is associated with a maximum degree of electrocardiographic abnormality. Figure 3 is a reproduction of representative electrocardiograms in case 2, while in Figure 4 are pictured some of the roentgenograms of the chest of the same patient. In this instance a marked degree of pericardial effusion is accompanied by minor electrocardiographic abnormalities. More lengthy discussions will be found in the legends for the figures.

Data of cases in this group are summarized in Table I.

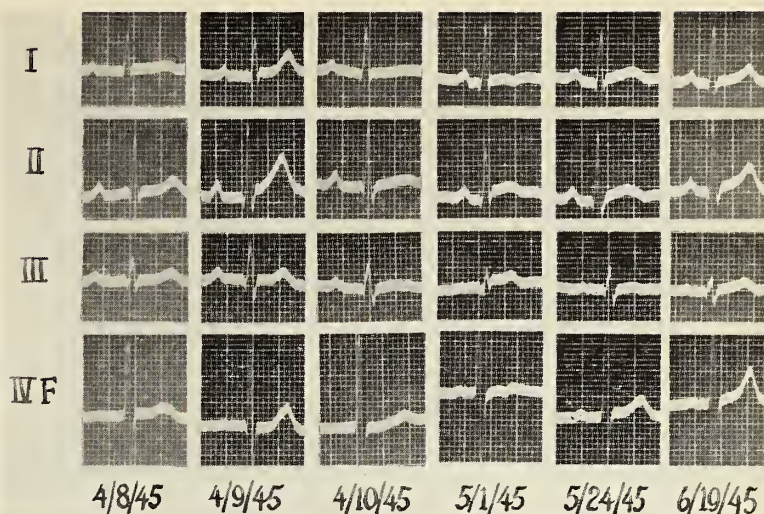
Group II.

Acute Pericarditis Without Pericardial Effusion.

Eight patients whose ages varied from 20 to 29 years (average 24.5) comprise this group. In five patients pericarditis complicated an attack of acute rheumatic fever, while in three patients pericarditis was considered to be of idiopathic origin. Since it was noted among the patients of Group I that effusions always occurred and, with one exception, were of maximal degree within the three weeks next following onset of pericarditis, criteria for acceptance of cases in the present group included the fact that at least two roentgenograms of the chest had been taken within that period and that normal cardiac silhouettes were present in each. Additional criteria included the absence of clinical evidence of pericardial effusion and sufficient electrocardiograms so that serial changes could be observed. Among the eight patients of this group electrocardiograms, numbered from the onset of pericarditis until the first normal record was obtained, totaled sixty-one, an average of 7.6 per patient. The electrocardiographic abnormalities were similar in every way to those observed in Group I. ST segment deviation occurred in only two patients. This is thought to be due, in part at least, to the fact that in only three patients were electrocardiograms obtained earlier than the ninth day of the disease. It has been shown² that segmental deviation usually occurs within the first few days following onset of pericarditis and is rare after the tenth day. Thus in five instances segmental deviation could not have been expected in the electrocardiograms studied.

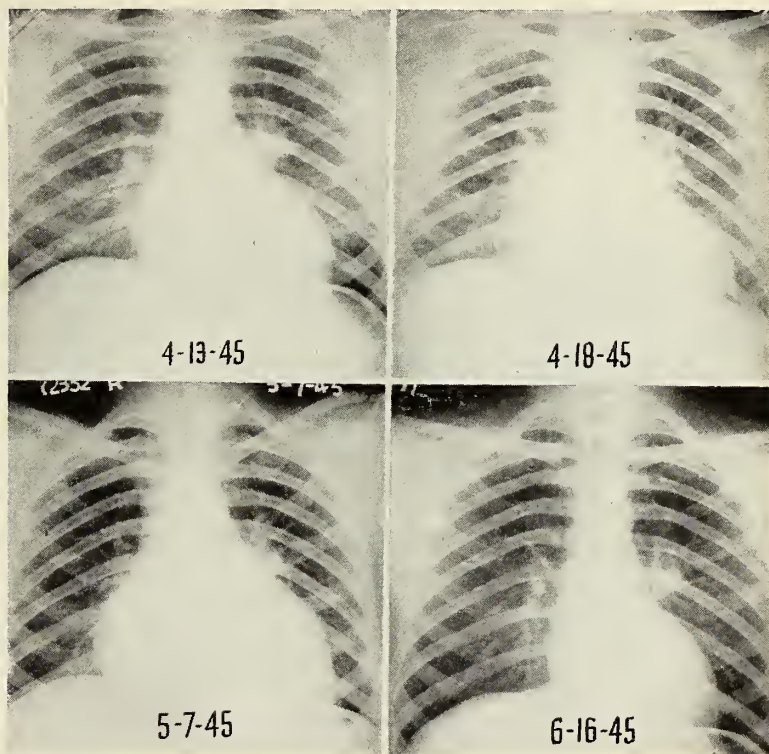
With one exception, T wave negativity occurred in the electrocardiograms of these patients. In six instances T waves in all four leads were inverted simultaneously. In one case T waves in the standard leads were diphasic and T₄ was in-

Figure 3



Case 2. Onset of acute rheumatic fever April 4, 1945. Daily electrocardiograms were taken and revealed second degree heart block. There were no symptoms referable to the heart until April 9, when precordial pain was noted. The electrocardiogram of the same day reveals elevation of ST₁ and ₂ with exaggeration and peaking of T waves in these leads and also T₄. The extremely transient nature of this characteristic change is illustrated by its absence in the electrocardiogram of the following day when the segments were isoelectric and T waves of low voltage. Although electrocardiograms were taken frequently during the succeeding two months, abnormalities were never of greater magnitude than illustrated here. Compare this series of electrocardiograms with the course of pericardial effusion as seen in Figure 4.

Figure 4



Case 2. These are roentgenograms of the chest of the patient whose electrocardiograms are illustrated in Figure 3. Although pericardial effusion of marked degree is present, electrocardiographic abnormalities were not of marked degree.

TABLE I
CASES WITH PERICARDIAL EFFUSION

Case	Age	Etiology	Number of X-rays	Number of Electro- Cardiograms	Maximum Degree of Effusion	Duration of Effu- sion in Weeks	Duration of Electro- Cardio- graphic Abnor- malities in Weeks
1	27	Rheumatic fever -----	9	15	IV	5	16
2	18	Rheumatic fever -----	6	19	III	12	8
3	22	Rheumatic fever -----	5	5	III	4	5
4	25	Rheumatic fever -----	5	9	III	2	12
5	23	Rheumatic fever -----	7	9	III	4	9
6	27	Rheumatic fever -----	3	8	II	2	4
7	27	Rheumatic fever -----	6	4	II	6	3
8	23	Rheumatic fever -----	5	7	I	3	5
9	27	Idiopathic -----	9	12	III	4	7
10	22	Idiopathic -----	7	10	II	5	9
11	21	Idiopathic -----	5	4	II	2	4
12	20	Idiopathic -----	5	8	II	2	5
13	24	Idiopathic -----	3	8	II	3	6
14	28	Polyserositis -----	4	5	III	2	4
15	34	Acute Glomerulonephritis -----	4	5	II	3	5
16	27	Trauma -----	4	5	II	3	4
Total -----			87	133			
Average -----			5.4	8.3			

verted. Abnormalities of the electrocardiograms were observed to persist for from three days to sixteen weeks, but in five cases were present for four to ten weeks. T wave negativity failed to develop in the case of a patient, 22 years old, who developed acute pericarditis during the course of an attack of rheumatic fever. A friction rub was present. An electrocardiogram taken in the first day of pericarditis revealed elevation of ST₁ and ₂ with upward concavity of the ascending limb of the T waves and moderate peaking of T₁, ₂, and ₄. These changes were present on the succeeding two

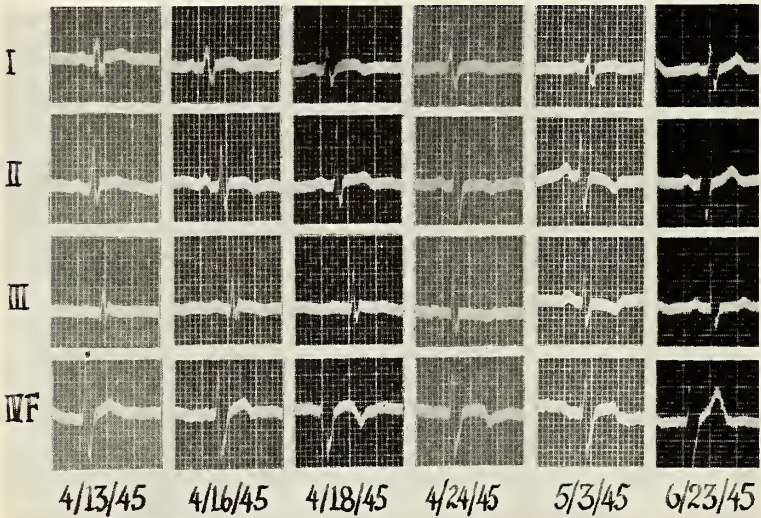
days, and on the fourth day the electrocardiogram was within normal limits. Electrocardiograms taken at weekly intervals for several months thereafter failed to reveal significant lowering of T waves or negativity of the T waves.

In Figure 5 are reproduced representative electrocardiograms taken in case 22. Three roentgenograms of the chest were taken during the period when pericardial effusion might have been present. The cardiac contour was normal in each roentgenogram.

Data from these cases is summarized in Table II.

Figure 5

Comment



Case 22. Onset of precordial pain April 9, 1945. First electrocardiogram taken April 13 reveals slight elevation of ST segments in Leads I, II and IVF. Subsequently, T waves become diphasic and inverted. The electrocardiogram taken June 23, 1945, is normal.

The electrocardiographic abnormalities encountered in this group of patients with acute pericarditis are worthy of emphasis. The earliest change noted was deviation of ST segments of all leads or of a combination of leads. Without exception in the cases herein reported and in all cases of pericarditis not associated with myocardial infarction that we have observed, this deviation has been an elevation. In fact, this is such an important point that it is felt that should elevation and depression of ST segments in a reciprocal manner occur in the electrocardiogram of a patient with acute pericarditis, the physician must regard this as strong evidence that myocardial infarction is present, as well. This has been stressed by previous authors.^{1, 3} Elevation of segments

TABLE II
CASES WITHOUT PERICARDIAL EFFUSION

Case	Age	Etiology	Number of X-rays	Number of Electro- Cardiograms	Duration of Electrocardiographic Abnormalities in Weeks
17	27	Rheumatic fever	2	14	17
18	25	Rheumatic fever	2	11	10
19	25	Rheumatic fever	2	5	5
20	24	Rheumatic fever	2	5	2
21	22	Rheumatic fever	3	7	3 days
22	29	Idiopathic	4	8	5
23	20	Idiopathic	2	5	4
24	23	Idiopathic	2	6	6
Total			19	61	
Average			2.3	7.6	

is of short duration and may occur for no longer than twenty-four hours. The data at hand suggest that the number of times it will be observed is in direct proportion to the frequency with which electrocardiograms are taken during the first ten days of illness.

Associated with elevation of segments there is frequently an increase in height of T waves with an upward concavity of the ascending limb of the wave and peaking of T. There follows a return of the segments to the isoelectric level. Subsequently, in most instances the T waves become of low voltage, and negativity of T waves in some or all of the standard limb leads and the precordial lead IVF occurs. This persists for periods varying from two to six weeks in most cases, but may last for sixteen weeks or longer. In all instances of acute pericarditis in this series, the electrocardiogram returned to normal. In the electrocardiograms reviewed low voltage of the QRS complexes was conspicuous because of its infrequency. No cause for this is immediately apparent.

In the electrocardiograms in which ST segment elevation was noted, it was observed that with one exception the segments returned to the isoelectric level before T wave negativity occurred. This may be a useful point in differentiating the electrocardiographic pattern of pericarditis from that of myocardial infarction, in which T wave negativity commonly occurs when the ST segments are elevated.

The most significant fact disclosed by this review is that the electrocardiographic abnormalities of the two groups were comparable with respect to character and degree. The presence of effusion in the pericardial sac influenced neither the speed with which electrocardiographic abnormalities became apparent nor the duration of time such abnormalities persisted. This fact is adequately demonstrated by a comparison of the two groups herein presented. As stated previously, the differentiation of pericardial effusion and cardiac dilatation by roentgenograms is difficult and may be impossible. If some error in this regard has been made, the chief point brought out by this review is not altered

since similar electrocardiographic abnormalities were noted in the two groups of cases.

It may be noted from Table I that the electrocardiograms of patients with effusions graded III and IV exhibited changes for from four to sixteen weeks, with the average being 9.5 weeks. On the average this is longer than was noted in patients with effusions graded I and II. The patient having a grade IV effusion had an abnormal electrocardiogram for a period of sixteen weeks. Some degree of effusion was present for five weeks in this case. This suggests that a greater degree of effusion is responsible for a longer duration of abnormalities of the electrocardiogram. But it may also be noted that with two exceptions the effusions graded III and IV were among patients with pericarditis of rheumatic fever origin. It may be that these are the more severe cases and that the greater degree of effusion into the pericardial sac is merely another expression of the severity of the disease. In addition, the duration of electrocardiographic abnormalities was approximately the same in the groups of cases with and without pericardial effusion.

One may conclude, therefore, that the presence of effusion into the pericardial sac is not the cause of electrocardiographic abnormalities observed in acute pericarditis in humans. In 1932 Barnes and Mann³ produced pericarditis of an inflammatory nature and observed electrocardiographic abnormalities similar to those occurring in acute pericarditis in humans. Fowler, Rathe and Smith⁴ reported similar experiences and noted that the period of T wave negativity was characterized anatomically by an active inflammatory reaction in the superficial layers of the myocardium and that return of the electrocardiogram to normal was associated with the histologic features of healing with fibrous tissue proliferation. These anatomical lesions were observed in human hearts by Vander Veer and Norris⁵ and by Bellet and McMillan.⁶ These authors believed that the electrocardiographic abnormalities were the result of these lesions.

These facts are not in disagreement with ob-

servations made during acute experiments in which fluid is introduced into the pericardial sacs of animals. Under these conditions, even though there have been observed electrocardiographic changes somewhat similar to those occurring in pericarditis in humans, it does not follow that the mechanism of production of electrocardiographic changes is the same. Stated differently, the experiment does not necessarily apply to the disease as encountered in man. For example, Katz, Feil and Scott,⁷ Foulger and Foulger,⁸ and Bay, Gordon and Adams⁹ report elevation of segments and T wave negativity simultaneously in some of their experiments. In acute pericarditis in humans, segmental deviation and T wave negativity are rarely encountered simultaneously. So far as could be determined, experiments employing injection of fluid into the pericardial sac in animals have not been carried out over a period comparable to the duration of pericardial effusion in man.

SUMMARY

Sixteen cases of acute pericarditis with effusion and eight cases of acute pericarditis without effusion have been reviewed.

The electrocardiographic abnormalities were observed to follow a definite pattern. The earliest change was elevation of ST segments with exaggeration of T waves in a positive direction. This was followed by return of the segments to the isoelectric level, lowering of T waves, and finally inversion of T waves in multiple leads. Return to normal was noted in from three days to sixteen weeks. Reciprocal deviation of ST segments was not observed in the electrocardiograms of this series of cases.

In the two groups of cases no essential difference was noted in the character or degree of electrocardiographic abnormalities. This substantiates the belief that the development of electrocardiographic abnormalities in cases of acute pericarditis is independent of the presence of effusion into the pericardial sac.

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DEATHS BY AGE: UNITED STATES, 1947

The average age at death in the United States during 1947 was 3.6 years higher for women than for men, according to figures released recently by the National Office of Vital Statistics of the Public Health Service, Federal Security Agency. The average (median) age at death for women was 66.9 years as compared with 63.3 for men.

In general, the average age at death has been increasing since 1933, the first year in which data are available for the entire continental United States, the increase being faster for women than for men. For women the increase was 13 percent, from 59.2 years in 1933 to 66.9 in 1947, as compared with an increase of 10 percent for men, from 57.5 to 63.3 during this period. For both sexes the average age at death was 64.8 years in 1947, or an increase of 11 percent, from 58.2 in 1933.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

Editorials

AMERICAN MEDICAL ASSOCIATION ASSESSMENT

THE House of Delegates of the American Medical Association at the recent interim session at St. Louis unanimously adopted a resolution favoring an assessment of \$25.00 on each member of the association. This action was taken after prolonged and earnest discussion on the subject of compulsory government health insurance. One of the points which this discussion developed was that the public-at-large does not realize what kind of medical service invariably ensues under any type of governmental control.

Funds which will be provided by the assessment are to be utilized in a nation-wide educational program. Mr. Clem Whitaker and Miss Leone Baxter of San Francisco have been employed as public relations counsel to direct the program. Mr.

Whitaker has announced that the campaign will be built around three objectives: 1. To awaken the people to the danger of a politically-controlled health insurance system. 2. To acquaint the people with the superior advantages of American medicine over the government-dominated medical systems of other countries. 3. To stimulate the growth of voluntary health insurance systems and prepaid medical care plans to take the economic shock out of illness and increase medical care to the American people.

Reaction to the assessment has been mixed, but most of the medical organizations and the majority of individual physicians have been enthusiastically in favor of the A.M.A. educational campaign and of the method of financing it. Some have ex-

pressed the opinion that the program should have been initiated at an earlier date, but very few disagree with the necessity for vigorous action.

The assessment is not considered as dues and is therefore entirely voluntary. Payment or non-payment will not in any way affect membership or fellowship in the A.M.A. The A.M.A. has always conducted its affairs without collection of dues from its members. This is the first time that an assessment has been levied, and it is especially appropriate that a highly democratic method such as a voluntary assessment should be chosen for this campaign.

The early response from Hoosier doctors indicates not only a widespread acceptance of the plan, but also a desire to have it launched at an early date. There has been a considerable number of doctors who paid their assessment even before any machinery was set up at the association office for handling and transmitting the receipts. At the time this is written, barely two weeks after the official receipt forms were distributed, a total of 1,060 assessments have been received. One county in the state is already in the 100 percent column, and six other counties are better than 90 percent paid up and are vying for the honor of joining the "100 percent Club."

The reactions of those who favor national compulsory insurance were prompt, and strenuous, and extremely vocal. The A.M.A. fund has been called a "slush fund," "war chest," and "lobby fund," and there have been prophecies that many American doctors would fail to pay the assessment. This prophecy, of course, is wishful thinking on the part of Mr. Ewing and his cohorts. It would have been a distinct advantage to them if such had proven to be the case.

It is indeed unfortunate that the great body of American physicians who are practicing under a system of free medicine must feel duty-bound to contribute their private funds to offset the propaganda campaign which is now being waged with taxpayers' money against that system of free medicine. However, the only alternative is to leave unanswered the extravagant claims and distortions of fact that are being given coast-to-coast publicity by those who would destroy the private practice of medicine.

There are some disadvantages incurred in the adoption of an educational campaign and incident to the collection of money for its support. These disadvantages were, no doubt, carefully considered prior to the adoption. They are evident in the counter-publicity which has emanated from the Social Security Administration since the plans of the A.M.A. were announced. It was to be expected that full advantage would be taken of the opportunity to designate the program falsely as a lobby.

On the other hand, much good will accrue as an indirect effect. *The Journal of the American Medical Association* reports a tremendous and very heartening response on the part of many non-medical organizations and numerous influential

citizens who have endorsed the campaign and pledged their support. The traditionally conservative attitude of the profession has allowed a scourge of propaganda for compulsory insurance to be spread before the public in magazines and in newspapers, without adequate rebuttal. Announcement of the A.M.A. program has highlighted the problem and has furnished a rallying ground for a great host of our friends. Now is the time for the medical profession to outline the objectives to be attained in improving medical service, and to recommend methods to be followed which will preserve the free practice of medicine.

STATE MEDICINE IS ALWAYS A FAILURE

MR. EWING has been taking exception to the practice of referring to his plan for compulsory national health insurance as "socialized medicine." He has been very careful during recent weeks to point out in many ways that, in his opinion, compulsory insurance is not a form of socialized medicine. He insists that compulsory insurance will not lead to nor develop into socialized medicine. He attempts a reassuring attitude in this regard by stating that the free choice of doctors, and the doctors' privilege of selecting his patients, will be preserved under compulsory insurance.

In short, he is paying a sort of tribute to the free practice of medicine, by selecting some of its attributes, and attempting the claim that his system will be able to adopt them and maintain them in a pure and democratic form.

Whether Mr. Ewing is correct in his statement that compulsory insurance is not "socialized medicine" depends largely on the definition of the term "socialized." The fact that most physicians use the terms interchangeably, however, should cause the government propagandists to investigate further into the characteristics of the two systems. There is a reason why doctors, when they examine a proposal for the universal mandatory prepayment of all medical expenses, refer to it as "socialized medicine," even though it claims to preserve many of the tenets of free medicine, and even though they might assume that it would do so.

The fact is that both compulsory insurance and socialized medicine have the same basic fault. This fault is so characteristic of both systems, and is so difficult to correct, that it makes them one and the same thing, for all practical purposes. It is a "built-in" feature, which cannot be altered, and which leads to the deterioration of medical service, whether there is a free choice of doctors or not.

It is a fault which cannot be eliminated as long as human nature is what it is. It is the fault which has wrecked or made useless every system of socialized medicine and every plan for complete

medical care under a compulsory prepaid system. It is a fault which is so glaring, and which applies to both compulsory insurance and socialized medicine so fundamentally, that any discussion of having one without the other is unthinkable.

Any plan which places an unlimited demand on a limited supply of an important service or commodity, will result first in a deterioration of the service or commodity in an attempt to fill the demand, and eventually in collapse of the entire plan.

History shows that all schemes for the furnishing of complete medical care for large portions of the population on a prepaid basis, whether by private or governmental means, have been overwhelmed by a deluge of individuals with trivial or nonexistent complaints. Patients who under ordinary circumstances would be willing and able to consult their physician in his office will, under a prepaid system, insist on house calls. Likewise, many patients ordinarily cared for at home are apt to insist on hospital accommodations and special nursing care, regardless of the need therefor.

This has been an unvarying pattern under all such medical service plans. The doctor's work is reduced to drudgery. He lacks the time to examine carefully and care for his patients. He actually does not have the time to determine which of his charges are ill and which are not.

Hospitals are so full of patients who are malingering or who have minor complaints that it is impossible to care for the seriously sick.

This is the reason why in New Zealand today there are twelve times as many hospital patients in proportion to the population as there are in the United States.

This is the reason an English practitioner recently wrote to the *British Medical Journal* and suggested that the government allow the doctor to charge each patient one shilling for each call, and charge the usual government fee, less one shilling to the government. This stratagem, the doctor thought, would serve to lessen the number of trivial calls, and would add a little monetary incentive to the day's work. He added plaintively that it might help the overworked physicians to refer to a busy day as a "good day," instead of speaking of it as a "bad day," as he observes they all do since July.

This is the reason why the standards of medical care have degenerated, and why the caliber of men attracted to the study of medicine has been degraded, in every country in the world and under all circumstances where compulsory health insurance or socialized medicine has been adopted.

This is why Mr. Ewing cannot successfully tell American doctors that his plan and socialized medicine are two separate entities.

NEVER SAY DIE!

WE reluctantly admit that there are doctors who profess an attitude of defeatism toward socialization of medicine. We wish such Faint-Hearts could have heard Henry Taylor's broadcast the evening of January 31. He was asked if this country must inevitably follow England's example in socialization. Mr. Taylor most ably showed the fundamental difference between our society and economics and that of Britain before socialization, and went on to say that we are not *obliged* to accept their ideas if we are willing to put up a fight for our own.

Why should we give up before we have begun to fight? We are up against men who, while they may not be averse to arguing in circles, distorting statistical facts, using as active campaigners F.S.A. and Public Health Service employees whose salaries are paid by taxpayers who may be opposed to such a campaign, and other deviations as yet uncovered, yet they are not all paragons of knowledge and mental acuity. Witness the following excerpts from a column by George Sokolsky in *The Philadelphia Inquirer*, December 21, 1948, as quoted by *Philadelphia Medicine*:

"On the radio program 'Meet the Press,' Oscar Ewing, Social Security Administrator, tried to switch the discussion to a denunciation of the physicians of this country who are raising a fund to defend what they believe to be right. . . . He denied their right to organize to defend their rights or to promote their interests. . . . I wonder if Mr. Ewing applies the same yardstick to Ed Flynn's Democratic organization in the Bronx, of which he is a leading figure. . . . Note these quotations from the 'Meet the Press' broadcast:

"Cecil Dickson: 'Do you know of any country that has more doctors in proportion to the population than the United States?'

"Ewing: 'I don't. I just don't know the answer one way or the other—whether there are or aren't. I can't tell you.'

"Ernest K. Lindley: 'How much would that (compulsory insurance) cost, do you think, in terms of the payroll tax?'

"Ewing: 'I don't—I can't answer you that. . . .'

"Lindley: 'Supposing we had a depression a year after you put the program in effect?'

"Ewing: 'Well, we'd have to—I don't know how we'd meet that. We might have to use general tax funds to meet a situation of that kind.'"

If you were armed with adequate information, don't you think you could give Mr. Ewing a pretty fair going over in a bout of mental fisticuffs? Don't you feel confident that the brains commanded by our A.M.A.'s Coordinating Committee for the Protection of the People's Health can take your \$25 assessment and put it to mighty good use? If you don't, we advise an immediate check of your hemoglobin. As for us—NEVER SAY DIE.

CANCER SYMPOSIUM

FULL announcement of the Second Annual Cancer Symposium appears in this issue of THE JOURNAL, on page 280. The two-day meeting will be held at Indiana University School of Medicine, Indianapolis, on Wednesday and Thursday, April 6 and 7, 1949.

The program is being planned along the lines of last year's symposium. The 1948 meeting brought many outstanding speakers whose addresses covered the entire field of diagnosis and treatment of malignancy. It was well attended, and the sponsors of the symposium this year are planning for an even more extensive program and for a larger registration.

The entire program is supported financially by the Indiana Cancer Society, and all physicians are admitted to it without charge. The Indiana Cancer Society is sponsoring the symposium, together with the Indiana State Medical Association, the Indiana University School of Medicine, and the Indiana State Board of Health.

The subjects to be presented and discussed will include the newer aspects of malignant disease, such as the field of radioactive isotopes and the endocrinological aspects.

The medical school is planning to welcome the registrants and will provide all the accommodations possible to make the two-day meeting convenient and worth-while. Doctors will be able to obtain their midday meals on the medical school campus, and can have telephone calls referred to them during the session.

PROGRESS IN WEST VIRGINIA

THE West Virginia State Medical Association has given its approval to bills introduced into the West Virginia Legislature providing for the establishment of a four-year school of medicine and dentistry, to be located in Charleston. Another bill provides for a state hospital at Charleston ("University Hospital") for diagnosis, treatment of chronic diseases, and rehabilitation services, including the treatment and training of crippled children and paraplegics. The services and facilities of the hospital would be available for clinical and teaching purposes to the proposed school of medicine and dentistry.

In addressing the legislature on these matters, Governor Patteson said,

"No disagreement should be found with the principle that the state owes a direct health obligation to its citizens. I do not refer to 'socialized medicine' or making our physicians servants of the state. I firmly believe, however, that our Health Department should be greatly expanded, and more emphasis placed on cancer control, venereal disease control, tuberculosis control, and the fight against infantile paralysis. We must step up our efforts to bring health services into the more inaccessible areas."

The governor of West Virginia had his feet on the ground when he framed that statement.

DAVID AND GOLIATH

ARE we downhearted?

Do we despair as individuals when we consider the forces arrayed against the freedom of our profession?

Let us not forget David. That \$25 assessment in a sling wielded by the A.M.A. will prove a powerful pebble. Ponder that and KICK IN.

PUBLIC RELATIONS PARADOX

THERE is a phase—or a fact, if you will—in our public relations which the individual physician must not lose sight of, and which he cannot emphasize nor reiterate to himself too often. It is, in a way, a paradox: *people still admire and have confidence in the individual family doctor BUT they seem to have doubts about the medical profession taken as a whole.* Part of the reason for this is obvious—the family doctor is a human being, while "the profession" is an abstract idea. But there are other factors, well stated below by the *North Carolina Medical Journal* for December, 1948.

"As this journal has repeatedly pointed out, most of the propaganda designed to smear the medical profession has been paid for by tax money. Mr. Oscar Ewing is constantly blasting the American Medical Association and the National Physicians Committee for opposing his pet scheme to socialize the medical profession. He charges 'the doctors' lobby' (doubtless the National Physicians Committee) with spending \$353,990 during the first nine months of 1948. Contrast this third of a million dollars with the \$75,000,000 that federal employees spent in 1946 for propaganda, much if not most of it on behalf of socialized medicine. The impact of this tremendous amount of tax money directed toward influencing public opinion has much to do with the large number of 'articles in the papers' favoring compulsory health insurance. If, however, the rank and file of medical men in this country will take it upon themselves to give their patients and friends the arguments against government medicine, they can exert enough counterpressure to restore the confidence of the people in the medical profession as a whole. The people have never lost confidence in their individual family doctors."

We hope our doctor readers are all as harmless as doves and as wise as serpents, for a word to the wise is sufficient.

VOLUNTARY PLANS EXPAND

MORE than 52,000,000 people, or well over one-third of the total population of the United States, are now protected under some form of voluntary hospital expense insurance, while voluntary surgical expense and medical expense insurance plans, newer types of protection, cover approximately 26,000,000 and 9,000,000 respectively.

At the same time, more than 31,000,000 persons, over half the employed civilians in the country, have benefits for loss of income due to disability, the basic type of protection sold by private insurance organizations writing accident and health insurance.



President's Page



PRAISE THE HOUSE OF DELEGATES AND PASS THE AMMUNITION

AT the Interim Session of the A.M.A. in St. Louis, the four chosen representatives of our Indiana State Medical Association and one hundred and seventy-one other members of the A.M.A. House of Delegates, representing the "grass roots" of American Medicine, took things in their own hands and decided "to do something about what was going on."

AMEN, BROTHER, AND HALLELUJAH

For ten years or more many of us have been hoping and praying that this day would come and that the A.M.A. would face the facts, realize its responsibility to American Medicine, and provide a militant leadership on the national front.

For the first time in its one hundred year history, the House of Delegates voted unanimously to assess each member of the American Medical Association \$25.00, and definitely decided to come out and fight for the freedom of the medical profession and the preservation of the best system of medical care in the entire world.

Just why they called it an assessment, I do not know. It is not compulsory in any way, and you may let your conscience be your guide.

It is a volunteer emergency fund equally apportioned to all whose interest is at stake.

And that is not all.

It is a national referendum that will tell the world just how many doctors here in Indiana and the United States willingly volunteer to work and contribute for the continuation of the practice of medicine in the American way.

Twenty-five dollars may be "peanuts" in your purse. It is not in mine, but it is

PEANUTS AS A PRICE FOR FREEDOM

It is peanuts, compared with the dues and assessments paid every year by the bricklayer, the hod carrier, the carpenter, and the mine worker.

It is peanuts compared with the \$100 to \$300 "kicked in" by the chiropractors as ammunition for their battle in the 1949 Indiana Legislature.

No doubt the courageous action of the House of Delegates in meeting the present crisis startled most of the A.M.A. members, and the idea of a \$25.00 assessment may be "revulsive" to some.

I am sure it jostled the "Grand Old Lady" at 535 North Dearborn Street and shook from the wall the hand crocheted motto of "The Ten Point Plan." But she is up on her feet and can no longer rock serenely in her chair with "dignity, propriety, and conservatism."

Dr. George F. Lull, Secretary and General Manager of the A.M.A. is now officially on record. In his letter of December 13 he states, "things are going to be different from now on; there will be no more theories that a crisis postponed is a crisis averted." He further informs us that a Planning Committee of ten members has been organized, representative of the Board of Trustees, the militant House of Delegates, and including himself and Indiana's own Roscoe Sensenich.

They are employing the nation's best professional campaign and public relations directors and, believe it or not, they are asking each State Medical Association to select its own representative on a nationwide Committee of Fifty-Three.

Yes, "things are going to be different from now on!" You can bet your life this Committee of Fifty-Three will demand action at the front and we who are to pass the ammunition will see that there are no more "duds" like the Ten Point Plan.

Here in Indiana I find many physicians and component medical societies enthusiastically endorsing the aggressive action of the House of Delegates. There are others who oppose the assessment and state they are dissatisfied with the past actions or inactions of the American Medical Association. I do not question the sincerity of my colleagues and shall not attempt to discuss or defend the past records of the A.M.A.

For many years American Medicine has been engaged in a cold war with Socialistic Medicine. We have offered an unorganized and passive resistance to the onward march of those who would destroy the freedom and initiative of American physicians. We have financially subscribed to various agencies to do our fighting for us.

All these agencies have done excellent work and no doubt retarded the crisis, but they failed to stop the hordes who blindly followed a gilded humanitarian banner.

Last November millions answered the siren call of a political panacea, followed a socialistic mirage, and voted overwhelmingly in favor of a government-controlled, compulsory health service. Congress has now convened to carry out the mandates of a sincere but misguided people.

Is it any wonder that Dr. Lull admits that a crisis postponed is no longer a crisis averted?

We walked into a booby trap when we thought the answer to our problems was in the ballot box.

The answer came from back home, from our own patients, and we did not like it.

We permitted American medical care to become a national political issue and failed to inform our patients on the fallacies of political medicine.

Today we face the final crisis in American Medicine: a crisis that can no longer be postponed.

Our only hope is to present a united, militant front, under the banner of the A.M.A., and enlist in service all physicians who would remain free men.

We should not quibble about peanuts or twenty-five hard earned dollars as a possible price for freedom.

We must present a national program of adequate medical care that will satisfy the American public and it must be presented at once in every hamlet and crossroad of America.

This campaign requires money, leadership, speed, and unity, far more than any political campaign.

If Harry Truman can change national public opinion in a few months with a political mirage, surely we can do it with facts, if we all work together.

In conclusion, I warn you there is one more booby trap ahead, a force more destructive than the atomic bomb. It is the insidious doctrine of

DIVIDE AND CONQUER.

It has enslaved a greater part of Europe and threatens not only the medical profession, but the freedom of the entire world. It is the thing that Oscar Ewing and his cohorts are hoping for and have openly predicted would happen to American Medicine.

I hope that every member of our County Medical Societies will calmly and seriously consider the danger that lies ahead and will realize that twenty-five dollars now may be

THE PRICE FOR FREEDOM.

For this reason I pray that we will stand together, accept the A.M.A. as our rightful leader, and not become the prey of those who would divide and conquer.

Augustus P. Haus

MEAT GRINDER ACCIDENTS IN CHILDREN

FRANKLIN E. HAGIE, M.D.

RICHMOND

AN electric meat grinder in operation is always fascinating to watch, and children as well as adults often push the meat down in the hopper of the grinder with their fingers, never thinking that the core or worm may catch their fingers, taking the hand into the grinder. During the last year I have had two such cases in children and they came into the hospital with the hand caught and held in the cylinder as shown in cut No. 1. The cylinder has been released from the motor and no bleeding is taking place at the time the youngster is brought into the hospital. Both children, aged five and ten years, had thrown the switch off on the motor with the free hand.

The amount of damage to the fingers and hand

cannot be determined until the hand is released. In one patient the ends of the fingers were beginning to show in the perforated plate but the damage was not any worse than on the other patient.

The patient is first given an anesthetic and then, by means of a wrench on the square end of the worm, as shown in cut No. 2, the worm is reversed, thus unwinding the caught hand, and exposing the damage to the fingers as shown in cut No. 3. The amputation of the damaged fingers is taken care of as shown in cut No. 4.

In this type of an injury a good point to remember is to use a wrench on the worm of the grinder in reverse in order to release the hand.

Figure 1



Figure 3

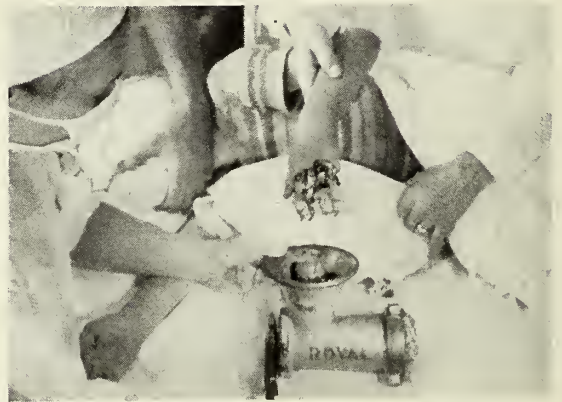


Figure 2

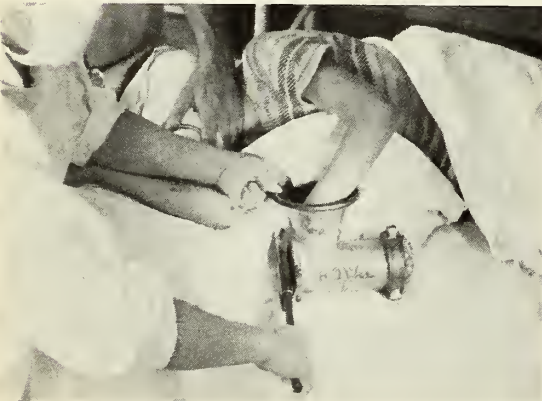


Figure 4



CONFERENCE OF MEDICAL SOCIETY OFFICERS

THE Conference of County Medical Society Officers was held in the Riley Room of the Claypool Hotel, Indianapolis, on Sunday, January 30, with a registered attendance of 150. This conference was known formerly as the Secretaries' Conference. As such it was originated by Dr. A. M. Mitchell, of Terre Haute. Under his leadership the meeting has grown and developed. He has served as its chairman each year since its inception, and at the close of the meeting Sunday he was unanimously selected as chairman of the 1950 conference. Because of its outstanding success its title has been changed to include all officers of the county societies, although all members of the county societies are urged to attend.

Dr. C. S. Black, of Warren, president-elect of the state association, made a short welcoming address in which he outlined the objectives of the meeting.

LEGISLATION

Dr. J. William Wright, of Indianapolis, co-chairman of the Committee on Public Policy and Legislation, gave a report on the activities of his committee in connection with the current session of the legislature. The main item of concern at the time of his report was the newly introduced bill calling for the establishment of a separate registration board for chiropractors.

COUNTY HEALTH COUNCIL

Dr. Joseph H. Clevenger, of Muncie, read a paper on "Relationship of the County Medical Society and the County Health Council," which is published elsewhere in this issue of THE JOURNAL. Dr. Clevenger touched on many aspects of the important subject of lay-medical cooperation in the solving of problems of medical care and preventive medicine. He described how it is possible for the medical profession to provide the guidance which is being sought by numerous lay organizations and by the public-at-large for the solution of health problems.

PUBLIC RELATIONS

Dr. Wemple Dodds, of Crawfordsville, chairman of the Committee on Public Relations, reported on the deliberations of his committee. He stated that a large share of the poor public relations in which the profession now finds itself can be attributed to the campaign for compulsory insurance. Undue emphasis on shortcomings, malicious misinterpretation of statistics, and distortion of facts have all been a part of this campaign. The result has been a noticeable change in the attitude of patients toward the medical profession as a whole.

Dr. Dodds recommended that doctors take advantage of the intimate personal relationship which exists between individual physicians and their patients, by spending a two or three minute period with each patient in discussing the ad-

vantages of free medicine and the disadvantages of state-controlled practice.

Dr. A. P. Hauss, of New Albany, president of the state association, spoke immediately after luncheon. He related briefly the history of the conference and praised Dr. Mitchell for his many years of work in its behalf. Dr. Hauss concluded with a splendid talk on the background for the A.M.A. educational campaign and spoke vigorously in support of the A.M.A. assessment.

A.M.A. OFFICE

Dr. Joseph S. Lawrence, director, Washington Office, American Medical Association, gave an informative talk which described the functions of his office in relation to the national legislative program. He emphasized that, as yet, the sentiments of Congress as a whole had not been established concerning many of the problems in the medical field, and urged the necessity of continued efforts on the part of the medical profession.

MEDICAL CARE

The voluntary prepayment medical care insurance program was discussed as to its status in Indiana by Mr. R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc. The status nationally was reviewed by Mr. Howard Brower, of the Council on Medical Service, American Medical Association. Both speakers reported on the steady increase in enrollment in the Blue Shield plans, and pointed out that continued and accelerated growth of voluntary insurance would be one of the best arguments against compulsory insurance. Mr. Saylor announced plans for broadening the market for Blue Shield in Indiana by conducting more community enrollment campaigns.

ASSOCIATION AFFAIRS

Dr. J. Neill Garber, Indianapolis, chairman of the Committee on Centennial Arrangements, outlined the plans for the Centennial Convention. He announced the tentative schedule for a four-day convention. Special features to celebrate the centennial will include a historical exhibit, a televised program to originate at Indiana University Medical Center, public meetings, and an expanded scientific session.

A brief discussion of the policies for THE JOURNAL, as determined by a recent meeting of the Editorial Board, was given by Dr. Frank Ramsey, editor. He emphasized that all items of economic and political nature, pertinent to the subject of socialized medicine, will be published during 1949.

The meeting was concluded by Mr. Ray E. Smith, executive secretary of the association, who discussed the actions taken at the midwinter meeting of the Council.

The last order of business was the unanimous election of Dr. A. M. Mitchell, Terre Haute, as the chairman of the conference for 1950.

MEDICAL PUBLIC RELATIONS AND GOVERNMENT*

CLEM WHITAKER

Public Relations Counsel for the California Medical Association

EVERY Californian, as most of you know, has an innate modesty, paralleled or surpassed only by the unassuming reticence of a good Texan.

It is this predilection for self-effacement and understatement which has caused us, in recent years, to deprecate the assumption that we have only the best things in California—and to admit that sometimes we also have some of the worst.

Any doctor or medical representative who has read some of the demagogic statements of some of our California politicians will know what I mean.

Seriously, California, with all its well-advertised sunshine, often turns a dark silhouette to the world. And no one knows it better than the doctors of California who have been forced to fight a bitter battle to avert regimentation of their profession.

We have more than our share of crackpots, dogooders and patent medicine fakirs—and as a consequence, the contagion of compulsory health insurance took serious hold in our state somewhat earlier than in most others. We have therefore achieved the dubious distinction of becoming a testing ground for the socializers.

That, undoubtedly, is the reason I am on this program, and have been assigned the subject—*Medical Public Relations and Government*.

The subject is broad and my experience with it has been limited to California, but I will attempt to report to you how the fight has gone on our particular battleground. Some of our experience may be applicable in other states, but some of it may not. That is something you can evaluate much better than I.

California medicine experienced its own devastating Pearl Harbor Day back in January, 1945! The attack came without warning—and from a wholly unexpected quarter.

Earl Warren, a Republican Governor, who had enjoyed the confidence and support of most of the medical profession—a supposedly conservative Governor, at the peak of his popularity—suddenly demanded the enactment of a system of compulsory health insurance by the Legislature.

Governor Warren, at that time unbeaten on any program of legislation he had requested, served notice on medical leaders he was prepared for a fight to the finish—and demanded that they capitulate or face the threat of even more drastic legislation.

In that 1945 legislative battle, Governor Warren had powerful allies. His socialized medical program was supported by the California State Federation

of Labor, by the CIO and the Railroad Brotherhoods; by several of the most powerful newspapers in the state, by the California League of Women Voters, and even by the conservative California Congress of Parents and Teachers.

Even staunch friends of the medical profession were fearful of the outcome. Many counselled surrender, believing it better to compromise and save something than to go down to complete defeat. The odds seemed hopeless.

How California medicine met that challenge is, I believe, one of the finest chapters in our state's hectic political history—a story which has new and reassuring significance today when the medical profession throughout the nation is faced with the prospect of a similar showdown battle in Congress.

I remember very vividly the first session of the Council of the California Medical Association which I attended, soon after New Year's Day in 1945. Our firm of Whitaker & Baxter had just been retained as public relations counsel for the C.M.A. And at that meeting, the Council was deciding on fundamental policies which would determine how 9,000 doctors conducted themselves in a fight to remain free men in the practice of their profession.

There were two vital and basic decisions reached at that meeting.

The first decision was that there would be no compromise, nor any surrender, under any circumstances. It would be a battle to the hilt, to the final roll-call. And if medicine went down to defeat in the Legislature, it would carry the fight to California voters on the referendum. Bluntly and finally, the Council declared: "There can be no compromise on principles!"

It was a staunch answer, worthy of the best traditions of the medical profession—an answer which gave heart and dramatic impact to medicine's cause. It had a ring like Winston Churchill's immortal defy: "We shall defend our island, whatever the cost; we shall fight on the landing grounds, we shall fight in the fields and in the streets; we shall never surrender."

The second decision that day was designed to fortify the first, to back up C.M.A.'s legislative representatives at the state Capitol with a hard-hitting campaign of public education, designed to get the medical profession off the defensive and into an affirmative position.

Medicine needed allies, and needed them quickly. It needed the aid of business and industry, civic organizations, women's clubs, religious, fraternal and veterans' groups, newspapers and radio.

The normal public relations procedure, of course, called for starting from the grass roots and mould-

* Presented before the National Medical Public Relations Conference, St. Louis, November 27, 1948.

ing public sentiment until it reached the top. But because of the shortness of time and the urgency of the situation, we built our house on a reverse floor plan. We started at the top and worked down; we reached out, with a small professional staff, and with hundreds of volunteers, to sell leaders in every walk of life on the soundness and rightness of medicine's position.

In three months, while the issue was pending at the Capitol, more than 100 powerful, state-wide organizations—the American Legion, the Veterans of Foreign Wars, the state Chamber of Commerce, the state Grange, the Agricultural Council, the California Taxpayers' Association, teachers' organizations, lodges, churches and farm bureaus—got into the crusade against socialized medicine and made their influence felt in the Capitol.

In three months, the number of newspapers supporting medicine's position jumped from 80 or 90 to more than 200—and more than 2,000 editorials and cartoons against compulsory health insurance were run in that 90-day period.

For three months, hundreds of doctors, members of the Women's Auxiliary to the California Medical Association, medical secretaries and friends of medicine spent every spare hour building public sentiment in their home communities. Doctors went from their offices or operating tables to speak before their luncheon clubs, their Legion posts, or their farm bureaus or chambers of commerce. Insurance men took time off from selling policies to sell the principles of voluntary health insurance as opposed to compulsory. Druggists talked to their customers, dentists to their patients.

At Sacramento, C.M.A.'s able, experienced legislative team, headed by Dr. Dwight Murray, now a member of A.M.A.'s Board of Trustees, and Ben Read, representative of the Public Health League of California, worked 18-hour days, talking to legislators, talking to their home constituents, rallying doctors throughout the 80 assembly districts and 40 senate districts to counteract the pressure being brought on legislators by the Governor's office and labor lobbyists. They reached out for help among the legislative representatives of business and industry and other organizations—and got it. They worked and fought without let-up.

Finally, when the roll was called, medicine won that fight in the state Assembly 39 to 38—by a margin of one vote! Legislatively, it was as great an upset as President Truman's victory over Tom Dewey. For the first time in his life, Governor Warren had gone down to defeat—and medicine had won the respect of the business community as a new, strong arm in the battle to save private enterprise.

Even before the Legislature adjourned, however, the House of Delegates of the California Medical Association met—and decided that continuing, constructive action must be taken to win the final victory. There were some very definite and well-considered objectives set forth.

It was agreed that *all* the people of California, not just the leaders in business and community life, must be told the facts of what socialized medicine would mean to them, in inferior medical care, in payroll taxes, in political meddling in their private affairs. The objective was to drive home the simple, understandable truth that political medicine is bad medicine—and that California should have none of it.

It was further agreed that the agitation for compulsory health insurance never would end, and that the battle could not be finally won until the people were convinced that the medical profession was taking leadership in providing prepaid, budget-basis medical care, and that government intervention was therefore unnecessary.

In effect, California medicine agreed that day that health insurance was coming, both in our state and throughout the nation, in the span of a very few years. The only question was whether it was coming on a voluntary basis, with proper medical safeguards, and with the medical profession administering it, or whether it was coming on a compulsory basis, with politicians at the controls.

It was decided that the California Medical Association would launch a public relations and advertising campaign, with paid newspaper space, radio, direct mail and intensive organization activity, to make the people of California health insurance conscious—and to convince them that the voluntary way was the American way to cope with the problem.

In carrying out that program, during the intervening years, the California Medical Association has staged *Voluntary Health Insurance Weeks* in 53 of the state's 58 counties, with the cooperation of city and county officials and community leaders. Medicine, the insurance industry and press have spearheaded the campaign; 120 mayors and 600 city councilmen have lent their names and influence to the drive. C.M.A. has published nearly 40,000 inches of paid newspaper ad copy in 420 daily and weekly newspapers—and approximately 30,000 inches of tie-in advertising has been donated by druggists, dairies, grocery stores, bowling alleys and even bars, to put over the Voluntary Health Insurance story.

California medicine, too, for the past several years, has had its own regular radio program on a state-wide network, reaching more than 500,000 people every Sunday afternoon. And the commercials, of course, have been selling California Physicians' Service, the doctors' own prepaid medical care plan. But in addition, on alternate weeks, we have clasped hands with the insurance industry—and sold their plans, too.

There's an interesting sidebar story in connection with C.M.A.'s radio program, which is called "California Caravan." Last year, "California Caravan" won the achievement award of the California Congress of Parents and Teachers for noteworthy

service in contributing to "the best of family listening." Three years ago, that same organization, the PTA, was supporting compulsory health insurance—and was bitterly critical of organized medicine. Today they are working with us, promoting interest in our radio program through the schools and their hundreds of thousands of PTA members.

I have only attempted to sketch some of the high points of our public relations program in this brief presentation. There's been a tremendous amount of spade work done which all of you, in the public relations profession, recognize as essential. We have 700 newspapers in California; our men have been in every one of those 700 offices, talking to editors, selling medicine's story. We've called on 400 presidents of service clubs, 280 officers of veterans' organizations, 500 officers of women's clubs, lodges and civic organizations, 200 insurance company officials, and almost every city, county and state official in California.

The job is still unfinished, but we are making progress. The impact of a mounting public opinion has been felt in legislative chambers. There have been no more 39-to-38 roll-calls.

On medicine's Pearl Harbor Day, in 1945, California Physicians' Service had about 125,000 members. Today it has more than 600,000!

Four years ago, only about 2,500,000 California citizens were enrolled in voluntary health insurance plans. Today there are more than 100 voluntary health insurance systems operating in Cali-

fornia, with over 5,000,000 insured members—a million more than Governor Warren promised to care for under his compulsory program.

We've come quite a way, but we're still not out of the woods. Our Governor, Earl Warren, who had hoped to go to Washington, is back with us—and we may have another showdown battle in the January session of our Legislature, but we are ready for the showdown!

We know this problem isn't peculiar to California, even though it may have been a bit more aggravated there. It is an Old World contagion which has spread to our New World—and which may menace not only the medical profession, but the health and economic and social welfare of our whole nation.

Medicine, today, is in the front lines in one of the most critical struggles in the history of our country—a basic struggle between two warring philosophies of government and economics. The fight is between socialism and capitalism, or communism and free economy. Call it what you will, it is a war to the death. But I have an abiding confidence in the soundness of the American people, if we get the facts before them. Congress won't decide whether compulsory health insurance is to become the law of this land; the people will decide that issue in the final analysis—and their decision will be the right decision, if the true story of American medicine is given them.

—Reprinted from *California Medicine*.

PRINCIPAL CAUSES OF INFANT MORTALITY,
INDIANA, 1947

ROBERT E. SERFLING, PH.D.*

INDIANAPOLIS

JUDGING from the first eleven months of the year, the infant mortality rate in Indiana during 1948 promises to be the lowest in the state's history. Despite continual improvement, analysis of the complete record for 1947 indicates need for more vigorous action on many phases of the problem. Since the first year of life is one of relatively rapid change with respect to growth of the infant, understanding of causes of death during the first year of life is clarified by examination of infant mortality at separate growth stages.

As children vary in their ability to cope with the external environment, causes of infant mortality may be grouped into (1) causes of death associated with variations in prenatal development and circumstances of birth, and (2) causes of death resulting primarily from postnatal environmental

contacts. Upon this basis infant deaths in Indiana during 1947 were grouped as follows: (Corresponding proportionate mortality is shown in the accompanying chart).

A. Causes of Death due to Factors Associated with Development and Birth

Cause of Death	Age at Death		
	30 Days to 1 Year	7-29 Days	0-6 Days
1. Premature birth.....	21	139	925
2. Birth injury	2	16	261
3. Congenital malformations	141	84	246
4. Asphyxia and atelectasis	8	9	141
5. Diseases peculiar to first year of life	9	16	75
6. Congenital Debility.....	16	8	10
Total	197	272	1,658

* Director, Division of Public Health Statistics, Indiana State Board of Health.

and obstetrics must make the major contribution toward reduction of this phase of infant mortality. Public health programs to provide improved care for premature infants afford another approach. The public health nurse can make a valuable con-

B. Causes of Death due to Factors Associated with Postnatal Environment

Cause of Death	Age at Death		
	30 Days to 1 Year	7-29 Days	0-6 Days
Principal Causes			
1. Pneumonia and Influenza -----	266	46	19
2. Diarrhea and enteritis -----	107	19	1
3. Accidents -----	79	5	15
4. Whooping Cough -----	44	--	--
All other causes -----	155	24	49
Total -----	651	94	84

Medical research in fields of physiology, surgery, tribution by counseling the mother during pregnancy and giving instructions and assistance to the mother during the early weeks of the child's life.

Despite great advances in treatment of pneumonia and influenza in recent years the hazard to the infant is still great. After infection, early treatment is essential. Education of the parent to take precautions against infection which may lead to deaths from penumonia, influenza, and the enteric diseases, is necessary. Education with respect to hazard of accidental death offers another means of preventing deaths of infants. Since present-day methods of active immunization against whooping cough provide an effective means of reducing mortality, the parent should consult with his physician in the early months of the child's life in order that protection may be given.

STRONG VOLUNTARY PLANS MAY AVERT
SOCIALIZED MEDICINE

R. S. SAYLOR*

INDIANAPOLIS

SUCCESS of the hospital and physician-sponsored Blue Cross and Blue Shield Plans in solving the problem of health care for Hoosiers appears assured. Membership in the former, which was organized late in 1944, has reached 375,000 and the Doctors' Plan has acquired over 240,000 members since its organization September 1, 1946.

Steadfast support by all Indiana doctors is prerequisite to the continued success and expansion of the benefits of these voluntary plans. And there are three sound reasons why these plans should have every possible assistance doctors can give. In the first place, they relieve the patient of worry over hospital and surgical expense and of the burden of paying for such care. At the same time, they assure the doctor of collection of his fee and make for better relations with the patient. And they are the profession's first line of defense against the threat of socialized medicine.

Powerful voluntary plans operating to the satisfaction of many millions of members will be more effective than anything else in averting the disaster that a bureaucratic plan of compulsory medical service would bring upon the nation. Socialization of medicine is in itself a dreadful thing that has resulted in the deterioration of medical standards in every country in which it has been tried: Germany, Russia, England, New Zealand, and many others.

Of more sinister import, however, is the fact that it is control of the medical care of the people that makes possible the complete socialization of the country. As Lenin put it, "Socialized medicine

is the keystone of the arch of the socialist state."

In the face of this, Indiana doctors are asked to take a couple of minutes with each patient to explain the truth about what a compulsory government plan will mean in higher taxes, red tape, delays, inferior service and lowered medical standards. The propaganda mills in Washington are grinding out articles and news and radio releases aimed at convincing Americans that they want and need bureaucratically administered medical care. Which means that the task ahead of those who believe in the voluntary way of solving America's problems is a huge one. Time is of the essence—but two minutes to each patient isn't much, compared with the hours that will be required for filling out government reports should the compulsory legislation be passed.

While enrollment in Blue Cross-Blue Shield is generally limited to those employed in groups of five or more, over thirty Indiana communities have made it possible for everyone in the community to have the protection afforded by membership in these plans. Hospitals, doctors and civic leaders sponsor the community enrollments to make the opportunity of membership available to the self-employed, the retired, and those employed in groups smaller than five. If you think such a program would be well received in your community, talk it over with some of the business and civic leaders and write to our Enrollment Department for assistance in presenting the project to your community leaders.

Literature is available for your waiting rooms and for enclosing with your monthly statements. Address your requests to our Public Relations Department, 54 Monument Circle, Indianapolis 4.

* Executive Vice President Mutual Medical Insurance, Inc.

NURSING FOR THE FUTURE

A WORKSHOP on Dr. Esther Lucille Brown's Report on Nursing, *Nursing for the Future*, was held at Indiana University January 5, 6 and 7, under the auspices of The Indiana State League of Nursing Education and the Division of Nursing Education, School of Education, Indiana University, in cooperation with the Indiana State Board of Examination and Registration of Nurses, the Indiana State Board of Health, and the Indiana State Nurses' Association.

The question posed during the workshop was "What Should Indiana Plan in Relation to Recommendations on *Nursing for the Future*: Commonly Called the Brown Report."

Participants were representative of all areas of the state, as well as of groups interested in health; among these were physicians, hospital administrators, directors of nursing service and nursing schools, educators, and the public or consumers of nursing. Each of these groups had opportunity during the first day of the workshop to express their reaction to the Brown Report and to offer suggestions regarding recommendations made by Dr. Brown.

Discussion followed these reaction reports, first by the workshop as a whole and then in smaller groups. Four groups were formed to discuss the following question: "What Should Indiana Plan for Improving Nursing Service and Indiana Systems of Nursing Education—Immediate and Long Range?" Major interest was evident in improving nursing service, in developing a practical nurse practitioner, and in developing and improving the whole area of nursing education.

On the last day of the workshop, specific recommendations for direction of efforts in Indiana were made. These recommendations were as follows:

I. Recommendations on Nursing Service.

- A. Initiate immediately basic research in nursing service—functional job and cost analyses.

In this connection, it was recommended that

1. A pilot study be done to determine the types and proportion of nursing personnel needed to give adequate nursing care.
2. A study be made of nursing procedures in order to determine how to eliminate certain time-consuming procedures and how to streamline other procedures which are now rather involved.

- B. Develop plans for securing cooperative approach and better inter-personnel relationships between nursing personnel, other professional personnel in the field of health, and the public.

In this connection, it was agreed that there is great need for a better public relations program to tell the real story of the present nursing situation in order to enlist public

support and understanding in solving present problems.

- C. It was suggested that the committee on personnel policies of the Indiana State Nurses' Association be asked to give consideration to a plan for securing recognition and appropriate financial return for the general staff nurse which would be commensurate with her skills.

It was further suggested that provision be made for horizontal as well as vertical advancement in all nursing service positions through establishment of such personnel policies that would provide these nurses with personal satisfaction, adequate remuneration, recognition for work well done, and the opportunity for professional as well as social growth.

- D. It was recommended that a survey be made immediately to determine the quantity of all types of nursing personnel needed in Indiana and that the findings of such survey be made available to all agencies and groups concerned with nursing service in the state of Indiana.

II. Recommendations on Nursing Education.

- A. Secure prompt consideration by officers of administration of accredited colleges and universities for the establishment of 4-year degree curricula for basic nursing education which could be followed by graduate nursing education of university caliber.
- B. Initiate immediately curricula for the preparation of the practical nurse.
- C. Continue and improve the present 3-year hospital curriculum.
- D. Start state-wide cooperative community planning for combining existing facilities, educational and clinical, for preparing the proposed types of nursing personnel.
- E. Prepare as quickly as possible nurses who are qualified to do research.
- F. Provide educational living and working environment in nursing education institutions which will attract and hold the type of nursing student needed to meet the current demands and needs of society for good nursing care.

In connection with this, it was pointed out that

1. Strong nursing service units be set up for educational purposes in all types of curricula proposed.
2. It is imperative that recruitment be broadened to reach male and negro students.
3. It is important to maintain active counseling plans for all types of nursing students in basic nursing education, gradu-

ate nurse education, and practical nurse education.

4. It is essential to endorse immediately a national accrediting program with publication of lists available for the public, especially prospective nursing students.

G. Improve and expand all proposed and existing nursing education programs concurrently.

A committee to initiate and implement these recommendations was also recommended. Mrs. Eugenia K. Spaulding, Director of the Division of Nursing Education, School of Education, Indiana University, was elected to appoint a small committee, which could select the proposed committee for implementing the recommendation of the workshop group on nursing service and nursing education.

HEART DISEASE RESEARCH

THE year 1948 may prove an important one in the history of medical science's long and arduous investigation of heart disease, according to a year-end summary issued by the Life Insurance Medical Research Fund. Financial support for heart disease research reached a new high during the year and as 1949 begins, more trained scientists are at work in the field and more research is in progress than probably ever before.

Although heart disease kills more men and women than any other disease, scientists had little financial support for their research in the field until three years ago. In 1945 the life insurance companies of the United States and Canada recognized the lack of research and set up the first private agency devoted entirely to research in the heart field. Each year since then the life insurance companies have contributed approximately \$600,000 to hospitals, universities and individual students. The total so far amounts to \$1,900,000.

During 1948 the funds supplied by the life insurance companies began to be supplemented by funds from two other sources, the American Heart Association, supported by public contributions, and the U. S. Public Health Service, supported by government funds authorized by the new National Heart Act. When the programs of the Association and the Health Service are in full swing, the total money available annually from these two sources and from the Life Insurance Medical Research Fund will exceed two million dollars, not counting additional millions to be spent in education, treatment, and other nonresearch activities.

Heart disease research during 1949, experts think, will continue to center around the three most serious heart diseases or heart "conditions"—rheumatic fever, arteriosclerosis, and hypertension. Study will also be continued on how the body's heart and artery cells work and how the blood flows through the body as a whole and through various organs.

One of the significant events in 1948 in heart research was the increased use of the radioactive isotopes, which scientists used to "flag" food elements, drugs and other substances introduced into the body. Out of this new technique have come studies of the role of cholesterol in arteriosclerosis, the changes which take place with age in the heart muscle, the actions of such drugs as digitalis, and the disturbances of body fluids such as those occurring in edema or water-logging of the body.

The relationship between arteriosclerosis and cholesterol received a great deal of investigation during 1948 and evidence is accumulating that it does play an important role in the development of hardening of the arteries. Cholesterol is included in such foods as eggs and milk, but it is also readily manufactured in the body itself and it is uncertain whether its presence in food is responsible for arteriosclerosis.

Research was also continued during 1948 in the effect of the "rice diet" in the treatment of high blood pressure, particularly at Duke University. Opinion still differs as to the value of this treatment, but the results are such as to require further study; at Duke, two-thirds of patients treated are reported to show improvement, often of marked degree, although some workers at other institutions have failed to obtain success. The diet is notable in its almost complete lack of salt.

The nature of heart disease, the Life Insurance Medical Fund declares, discourages any hope of some new and startling cure or method of prevention in the next few years. But medical knowledge about the disease and about how the entire cardiovascular system functions is increasing at a dramatic rate, laying the same kind of foundation in the field of heart disease as preceded the discovery of insulin in the field of diabetes and the discovery of the sulfa drugs, penicillin and streptomycin in the field of the infectious diseases.

RELATIONSHIP OF THE COUNTY MEDICAL SOCIETY AND THE COUNTY HEALTH COUNCIL*

JOSEPH H. CLEVENGER, M.D.

MUNCIE

INEVITABLE changes in the evolution of human society have brought about a change in relationship between the medical profession and the people whom it serves. The hospital has practically replaced the home as the place for treating the sick. The advent of specialism in the profession has led the people to acquaint themselves fairly intimately with a number of physicians, any one of whom they feel free to consult when the occasion demands. The inclination of the people of the United States to change their place of abode and to travel unrestrictedly tends to prevent close relationship with a particular physician. The movement of our population to urban centers where the intimate associations of small community life is lost makes the choice of a physician a haphazard process. The necessity for the greater dissemination of public health facilities and the progress of preventative medicine has thrown a heavier load upon the profession. The development of laboratory procedures essential to the diagnosis and proper therapy of seriously ill persons, and the obligation to train properly and adequately pay personnel to render these services has not only changed the patient-physician relationship, but increased the cost of illness. Many other changes could be cited. It is not my desire to debate the merit or undesirability of these changes, but to direct attention to their presence and to discuss the formation and operation of an organization; namely, the County Health Council, which may be used to improve the relationship of the profession to the people in the present state of society.

A narration of the inauguration of a county health council in Delaware County will present information apropos of the topic for discussion. In October of 1947 the county medical society proposed the adoption of a full time city-county health department. A formal resolution containing the proposal was adopted, and immediately following the November election copies of the resolution were sent to the newly elected mayor, city and county officials, the local newspapers, and other organizations and persons whom we thought would be interested. The press and all concerned were favorable to our proposal, but nothing happened. The officers of the society and the chairman of the Committee on Public Health discussed the matter with the mayor personally and secured his approval of the plan. The same group visited the County Board of Commissioners and the City Council informally, where the question of costs and the effect

on taxes was the main point of issue and not the merits of the plan. It was quite evident that our proposal was not sympathetically received.

The problem was discussed before the society and the consensus was that we could not accomplish our objective unless the people of our community were in accord with our proposal, and would take positive action to bring about its adoption. This was a profound decision. It implied that the people of our country are responsible for the character of medical service in their local community and that the profession has only a professional service responsibility and perhaps an advisory responsibility in matters pertaining to health and medical service. This is a basic fundamental principle which should guide us in all our relations with the public, and unless we acknowledge its validity we will fail to maintain the estimable position in society which has been our prerogative for many years.

With this principle in mind, the medical society decided that it was the proper agent to initiate the formation of a county health council; that the society would accept financial responsibility for the initial costs of organization; that the society would exert every effort to dictate the adoption of proper objectives for the council; that membership in the society should include representatives from six groups:

1. The medical profession.
2. Allied and auxiliary professional groups.
3. Citizens groups indicating a continuing interest in health and medical care.
4. Volunteer agencies organized for the purpose of developing and expanding special phases of health and medical services.
5. Governmental agencies concerned with health and medical care.
6. Labor organizations.

We thought the selection of membership would be an important factor in the progress of the venture. Allied and auxiliary professional groups have appreciated the advisability of using the talents of influential and health-conscious citizens of our local communities. If these individuals had had more logical and constructive guidance by members of the medical profession they would not have today such a confused opinion of medical problems. Any plan which seeks to improve the public relations of the profession must include methods for presenting medical affairs in a logical, unbiased manner to these individuals, and for directing their talents in a more constructive manner.

* Presented at the Conference of County Medical Society Officers, at Indianapolis, on January 30, 1949.

The need for including representatives from labor organizations is obvious. Farmer organizations and women's clubs representation is included in group three. The influence of women's clubs in disseminating information we thought to be essential to the success of the organization. Therefore, more than two hundred invitations were issued to organizations which fell into the classifications enumerated above, requesting that they send representatives to a meeting to be convened for the purpose of forming a county health council. A brief statement of the purpose of the proposed council was included. The response was gratifying, and indicative of the interest of the public in medical affairs. Undoubtedly the response was indicative of the esteem for the profession, for the invitations were issued by the county medical society and it was designated as the sponsor. One hundred and seventy-six representatives attended the organization meeting.

The county medical society accepted the responsibility for the initial costs of organization because it was the sponsor, and it was the feeling of the members of the society that if we could establish a permanent organization for promoting the ideals of medicine we would be more than repaid. The officers and the health committee chairman had consulted a member of the social science department of Ball State Teachers College on several occasions and through his kindness we were able to secure the help of students in typing the invitations. Other expenses included the rental of an assembly hall, stationery, postage, the mimeographing of information sheets, *et cetera*, all of which was not excessive.

Our Public Health Committee and the officers of the society were delegated the responsibility for arranging for the procedures incidental to the formation of the council. A considerable amount of ground work was necessary. We felt that the president of the new organization should be a person who had the respect of every individual in the community; he should be sympathetic with the program of good health and good medicine; he should be a person experienced in community organizations; and he should not be a physician, for we were all of the opinion that the council should be primarily a lay organization. There was one individual whom we thought was ideal for the position so we approached him unofficially, but were unsuccessful in securing his consent to serve. Time was growing short, so we decided that since this was to be a lay organization we would trust the wisdom of the invited representatives to elect a good leader. We feel that our judgment was vindicated, for the chosen president has been an excellent leader, and has cooperated with us in every way.

At the meeting provisions were made for by-laws, an executive committee, financial resources and a statement of objectives. The executive com-

mittee consists of representatives from the following organizations:

1. Federated Women's Clubs.
2. Muncie Career Women—BPW.
3. Delaware County Farm Bureau.
4. Muncie City Health Officer.
5. Ball State Teacher's College—2 (Social Science Department).
6. Trustee of Hamilton Township—Delaware County.
7. Home Economics Clubs.
8. Muncie Chamber of Commerce.
9. C.I.O. Women's Auxiliary.
10. Delaware County Chapter, American Red Cross.
11. Health Director, Muncie City Schools.
12. County School System.
13. American Federation of Labor.
14. Medical Society—2.

We have been impressed with the hearty interest which the Executive Committee has displayed, and with the sincere interest in medical affairs which they have demonstrated.

The committee for the proposal of objectives for the council submitted the following, which have been formally adopted:

1. To provide an opportunity for exchange of ideas and promotion of cooperation among those forces working for good health in the community.
2. To interpret the public health program to the community in order to have it adequately used and supported.
3. To assist in maintaining high standards of medical service.
4. To assist in developing a cooperative program with all of the public health agencies of the community.
5. To study continuously the community to discover unmet health needs and develop plans for meeting those needs.
6. To develop a well-rounded community program and deep public interest in health.
7. To express itself with strength and authoritative information on health legislation.

No member of the profession could criticize these objectives. No professional committee could formulate a better group to guide a lay health council.

There is an axiom that the proof of the pudding is in the eating. Comparatively speaking, the necessity for a County Health Council is attested by its achievements. It was decided early in the formation of the Delaware County Health Council that the first problem to be attacked would be promotion of a city-county health department, and that other projects would receive secondary attention until this objective had been attained. The members of the executive committee of the council have discussed the health department with officials

of the city and county, but it appears that legal action will not be taken soon. Last Wednesday evening an informal meeting with the City Council was held, and it would have been comforting to any member of the profession to have heard the logical presentation of arguments for a full time health department which the lay members of the Executive Committee expressed. Plans for a meeting with the Board of County Commissioners have already been made and the City Council has suggested an informal, combined meeting of the council, the commissioners and the committee. This activity is reported to show that the organization we sponsored remains intact and active. Should we not be able to obtain action from officials at this time, we have an organization which already has spread information about the proposed department and we have no fear that we can bring the proposition to a referendum vote and succeed by a substantial vote.

The members of the medical society have benefited by association with the lay members of the Health Council. The latter have been free with their criticism of medical affairs. The council offers a medium for the profession to present its views

of these criticisms where there is no accusation of professional prejudice, for we have obtained their complete confidence in our sincerity. Many constructive criticisms are voiced. It is our responsibility to pay attention to these warning words and correct our deficiencies. We do have them.

Our future plans anticipate the use of the council in sponsoring lay speakers who will discuss pertinent information regarding compulsory health insurance. Our county society is in the midst of a program sponsoring a greater enrollment in Blue Cross Hospital Service and Mutual Medical Insurance. If the necessity arises we can take this program to the council. There are a number of pressing problems which undoubtedly will be referred to the council to secure lay action.

In conclusion, it is the earnest opinion of the speaker that a county health council can render service to the profession and the public. The county medical society must take sincere and continued interest in the conduct of affairs of the council and guide its activities. The results obtained will be in direct proportion to the conscientious influences exerted by the profession.

NATIONAL CONFERENCE ON MEDICAL SERVICE

THE twenty-second annual meeting of the National Conference on Medical Service was conducted in Chicago on February 6, 1949. This is one of the most unusual of all medical organizations. It does not have a membership in the usual sense of the word. It has no constitution, and collects no dues. Despite the lack of the customary appurtenances of an organization, the conference has increased in scope and importance. Each year it meets to study and discuss the current problems of medical service.

Its participants are drawn from among the officers, committeemen, and members of the county and state medical societies. The meetings are conducted as open forums for free discussion and frank opinion. None of the questions discussed is voted upon and no official decisions are reached.

The 1949 conference was no exception to the fact that the most important social and economic problems are included in the programs.

LEGALIZED MEDICAL RESEARCH

The conference was opened by an address by its president, Dr. E. F. Sladek, of Traverse City, Michigan, following which the medical problems of medical research were outlined by Dr. Chris J. D. Zarafonetis of the University of Michigan. He introduced the subject by pointing out that the present-day concern over the problems of medical practice tends to obscure the problems of research, which are however very important since advances in practice are dependent on advances in research.

The number of problems inviting medical research is steadily increasing since each new found

fact usually reveals several unknowns not appreciated before. The number of investigators is limited, due in part to the limitation of funds. Facilities and material for projects are in ample supply at present.

Financial support is the ingredient which is definitely limited, and the supply of which is undergoing fundamental change. There are four main sources for research funds. Philanthropic individuals have been liberal contributors in the past, but their ability to continue on a large scale has been hampered by taxation. The public now responds generously to requests for funds for research on specific diseases. Pharmaceutical firms have always aided medical research in a substantial way and will probably continue to do so. The Federal government through grants-in-aid by the Public Health Service is becoming a larger and larger supporter of research.

Dr. Zarafonetis expressed the opinion that the Public Health Service and its National Research Council had distributed research funds in an equitable manner, and had not interfered with the projects by applying any sort of controls. This he attributed, in part, to the establishment of a panel of consultants from outside the Public Health Service, for study and recommendations on proposed research schemes.

LEGAL PROBLEMS OF MEDICAL RESEARCH

Dr. George Wakerlin of the University of Illinois pointed out that, in spite of the fact that the general public is overwhelmingly in favor of medical research, as evidenced by its financial support

of drives for research funds for many diseases, the laws of the nation generally provide only half-hearted support, and even in some instances are detrimental to the cause of research.

Opposition by a very small minority of citizens headed up by anti-vivisection groups is responsible for this unsatisfactory state of affairs.

Dr. Wakerlin urged the medical profession to initiate vigorously and support state laws which would definitely legalize medical research and which would also make animals obtainable.

**PROGRESS OF THE WORLD HEALTH
ORGANIZATION (WHO)
PROGRESS OF THE WORLD MEDICAL
ASSOCIATION (WMA)**

These are two international medical groups with identical aims, but of totally different origin.

Dr. Frank Calderone, Director, American Office, WHO, described the World Health Organization as one of the operating agencies of the United Nations. Its importance is due to the fact that many of the world's economic ills are the result of chronic and widespread sickness.

The activities of WHO are performed in part by an educational and demonstration function which seeks to increase technical know-how throughout the world. Its activities also include an epidemiological agency which is now very useful in the early study of possible pandemics. WHO is also concerned with standardization of drugs, nomenclature of diseases and causes of death, and laboratory practice.

Although a part of UN, the World Health Organization contains representatives of some nations which are not a part of UN.

Dr. Calderone illustrated the economic importance of disease control by stating that the money spent in Greece for medical purposes has produced an eight-fold return in productivity.

Dr. Creighton Barker, Executive Secretary of the Connecticut State Medical Association, described the World Medical Association as a professional organization.

Its aims are:

1. To promote closer ties between medical organizations and doctors over the world,
2. To study professional problems on an international basis,
3. To exchange information,
4. To present to WHO the results of its studies,
5. To improve health,
6. To elevate the standards and esteem of the medical profession, and
7. To promote peace.

One of the accomplishments of the WMA was the adoption, at its Second Annual Assembly in Geneva, September, 1948, of a modern form of the Hippocratic Oath. It is known as the International Pledge and is to be subscribed to "at the time of being admitted as a member of the medical profession:

"I solemnly pledge myself to consecrate my life to the service of humanity;

"I will give to my teachers the respect and gratitude which is their due;

"I will practice my profession with conscience and dignity;

"The health of my patient will be my first consideration;

"I will respect the secrets which are confided in me;

"I will maintain by all the means in my power, the honor and noble traditions of the medical profession;

"My colleagues will be my brothers;

"I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

"I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use any medical knowledge contrary to the laws of humanity.

"I make these promises solemnly, freely and upon my honor."

**MEDICAL PROGRAM OF THE UNITED MINE
WORKERS OF AMERICA WELFARE AND
RETIREMENT FUND**

Dr. Warren F. Draper, Executive Medical Director of the fund, described the activities of the Welfare and Retirement Fund, which receives twenty cents for each ton of coal mined, as consisting of:

1. Payment of pensions to retired miners,
2. Payment of disability benefits to those who are unable to work because of illness or injury after industrial compensation payments have ceased.
3. Payment of death benefits to dependents, and,
4. Health and hospital activities.

Under the fourth category the fund has underwritten the financial support of the medical care of 400,000 workers, together with the dependent members of their families.

The plan for accomplishing this by utilizing private practitioners and private hospitals was evolved by a committee of physicians interested and skilled in the field of industrial medicine.

The plan expects to upset the present medical care system as little as possible. The Welfare and Retirement Fund only assumes the financial burden, and does not expect to operate hospitals or employ physicians on a salary to render medical care.

One class of miners which are being cared for now are those who are unable to work, but whose pensions and disability benefits in the past have been insufficient to provide adequate medical care. Dr. Draper described some of these cases as being in "unspeakably terrible condition."

These are the cases which in former days were treated by doctors on a charity basis or for very small fees, or who received no care at all. Their number is such that considerable time is being

required merely to discover their existence and location.

As they are found and as hospital and treatment facilities are available they are being cared for on a private basis, with payment of fees from the fund. Dr. Draper stated that his organization did not have any set schedule of fees, but was asking the doctors to set their own fees, and to charge the minimum fee for which they felt they could provide good medical service.

POSTGRADUATE EDUCATION OF THE DOCTOR

The responsibility of medical schools in postgraduate education of the doctor was discussed by Dr. George N. Aagaard of the University of Minnesota.

He defined the chief function of medical schools as undergraduate education. However, he stated that a newly graduated M.D. was not a finished product, and even though he were, he would not be at the end of a few years without continuing education. Since medical education must be a continuing process, the medical schools are bound to take postgraduate work as an important secondary function.

Medical schools can perform this function well, since they have the teachers and facilities.

The University of Minnesota utilizes three media for this purpose:

1. Doctors are urged to attend and are made welcome at the regular undergraduate seminars and conferences.
2. Special courses are conducted at the medical center and elsewhere, usually on a weekly schedule.
3. Intensive courses of several days of con-

tinuous instruction are given at the medical center. Two or three day sessions are found to be more effective than longer ones.

Dr. Aagaard also mentioned that schools could further aid practicing physicians by furnishing doctors to serve as substitutes to cover the doctor's practice while he is being instructed.

STATE MEDICAL SOCIETIES

Dr. C. W. Smith of Harrisburg, Pennsylvania, described the program of postgraduate education which was organized by the State Medical Society of Pennsylvania.

Courses are given at centers over the state located so as to enable each doctor to attend by driving 100 miles or less. One day a week for five weeks in the spring and five weeks in the fall were chosen so as to eliminate the adverse elements of heat in the summer and bad driving conditions in the winter. The day of the week is chosen separately at each center by vote of those who expect to attend.

The instructors are drawn mainly from medical schools. They are reimbursed from funds obtained by fees paid by the registrants. Administrative costs of the courses are borne by the State Society.

The subjects are chosen by a committee of consultants with high priority being given to requests of the registrants.

Since its birth three years ago the system of instruction has increased its enrollment each year. The centers of instruction have increased from six to eight to eleven. The plan is financially solvent and is a huge success.

SUCCESSFUL BLOOD FILTER DEVELOPED IN DETROIT

The story of the development of a much-needed new type of blood filter at Harper Hospital in Detroit, was recently revealed in the *Journal of the American Medical Association*. The new filter, of "bakelite"-impregnated cotton cloth, is the first to successfully meet all the requirements of being efficient, free from technical difficulties, disposable, and inexpensive.

The need for such a filter has existed ever since earliest investigations showed that fibrin particles, clumps of white blood cells, and even small blood clots occur in blood stored for even a few hours. These must be filtered out before the blood can be safely used for transfusions.

Until about two years ago, the best type of blood filter developed was made of stainless steel mesh, formed into closed cylinders and enclosed in a glass housing.

They were so costly that repeated use was necessary, and they were difficult to clean properly.

Just before the close of World War II, doctors of medicine concerned with the blood bank at Harper Hospital procured some "bakelite"-impregnated filter paper. Though this early material did not prove suitable for blood transfusion purposes, the principle of resin-treated materials did seem very promising.

With salvaged red blood cells from Red Cross blood donor service, dozens of fabrics were tested. It was finally decided that cotton cloth with a mesh of 90 to 100 square per inch, when impregnated with the resin, was ideal for filtering human blood. The material was then thoroughly treated for any possible toxic effects.

Since then, over 11,000 transfusions have been given with this filter at Harper Hospital, and it has been standard equipment in four other Detroit hospitals.—*Michigan State Medical Society Health News*.

Voice of Medicine

The Journal, Indiana State Medical Association,
1017 Hume-Mansur Building,
Indianapolis, Indiana.

Dear Sirs:

I wanted to make a suggestion at the recent Conference of County Medical Society officers, but time was too pressing, so perhaps a letter might do. At this conference some of the problems facing the profession, such as socialized medicine, quacks, *et cetera*, were discussed and some excellent suggestions made as to how these might be counteracted for the benefit of the people. However, I feel that one most important angle was almost overlooked, and that is the teaching of health in our public schools. I doubt whether very many of the great mass of people who decide elections have a very good idea of what scientific medicine consists of, the cause of disease, the enormous amount of research going on, *et cetera*. I have been school physician for several years and have attended some panel discussions on school health, and it is my opinion that the teaching of health in many schools is a waste of time as far as giving the student anything of practical value is concerned.

One of the suggestions that came out of the school health conference sponsored by the State Medical Society last year was that an advisory committee be set up in each county, to work with the schools. Physicians should be of great help on a health program, for health is our business. We see the results of poor teaching in our offices every day. There is no idea that the physicians would try to dictate what should be taught in our schools. It is bad for any group to do that. But for the doctors to cooperate in an immunization program, or in making examinations, or in taking small groups of students through our modern hospitals, would be a few practical ways of teaching a scientific health program.

In Tennessee the physicians help put on a radio health program which is used to supplement the teaching in both the rural and city schools. This program also gets into the homes and is doing a great deal of good. Moving pictures could also be produced to give the students a better idea of scientific medicine.

The Wisconsin Medical Society sends out bulletins to the teachers, school board members, colleges, *et cetera*, to aid in the health program. I believe most teachers would be willing to cooperate on such a program if they had some help from the medical society.

On a higher level the State Medical Society could cooperate with the State Board of Educa-

tion in a program of better training for health teachers, and a better curriculum for the schools.

The main difficulty we have to overcome is ignorance, and it does not do too much good to deal with adults who have already made up their minds.

Sincerely,
B. N. Lingeman, M.D.

December 27, 1948.

Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis, Indiana

Gentlemen:

As the present year closes and we of the Veterans Administration approach the third anniversary of the Department of Medicine and Surgery, it is most fitting and proper that we express our appreciation for the cooperation and help furnished by your organization as well as the individuals making up the various components. It is our wish also to enhance and merit even a greater coalition and closer liaison if and wherever it is possible to accomplish the utmost in our directed mission.

It is believed that by such a program, even much more than has been attained can as yet be accomplished. We still in some areas are confronted by staffing problems, and the availability of certified specialists and it is hoped that through cooperation we will yet, in all of our facilities, through concerted efforts and cooperation, be able to attain our goal of furnishing the best of medical care available to all veterans in all localities.

It is believed and hoped that members of your association can find time to interest themselves in our welfare as a matter of public interest and endeavor, such a relationship thus increasing public interest and community relationship to the benefit of all. Such a program will do much to improve morale within the ranks of the Department of Medicine and Surgery, improve the type of medical care not only in our hospitals, but it is believed that it will possibly elevate the plans of medical service to the individual communities, if such is possible. It is likewise believed that such a procedure will also assist us in our staffing problems in a few needed localities as well as work to the best interests of better medical service to the communities and states. Your interest and assistance in such an accomplishment is heartily solicited.

DELMAR GOODE, M.D.,
Branch Medical Director,
Veterans Administration.

Journal of the Indiana State Medical Association, 1017 Hume-Mansur Bldg., Indianapolis, Ind.

Not beyond memory, when the means of transportation were rather primitive, doctors served all the needs of their communities. My grandfather, a country doctor, made most of his living from a farm. He traveled on horseback in bad weather, with saddlebags filled with compound tincture of opium, ipecac, the various balsams and a host of impedimenta that have changed into clear crystalline active principles. He pulled teeth, delivered babies, treated malaria and typhoid by the wholesale, and repaired trauma of all kinds. His clinical records looked something like this:

Johnny Jones . . . (date).

Or, on rare occasions, something like this:

Johnny Jones . . . \$1.80 plus 1 bushel of corn.

His attitude towards surgery was hypercritical because as a young physician he had been forced to hold in his arms a young boy patient while his leg was amputated for a malignant bone tumor. At the completion of the amputation, the surgeon decided that the leg should come off higher and while he did this, immediately, without anesthetic or antiseptic, the child expired.

My grandfather's son, my father, saw the development of general anesthesia and aseptic surgery. In his own right he was a pioneer and one of the first specialists in Indiana. He passed through the era when surgery was mostly exploratory and somewhat experimental. He, too, served the needs of his community in general surgery, gradually specializing toward abdominal surgery as the years passed and more men entered the field of surgery.

With the passage of time and because medical science has been an ever-expanding art and profession, as well as a science, new diseases are recognized and improving methods permit what was impossible to become almost matter-of-fact. For instance:

The devotion of the research mind to an insurmountable problem has brought unbelievable advances to chest surgery. It is not uncommon today that a lobe or more of a lung is removed, and so no longer is it necessary for a patient to travel halfway around the world to the lone, great specialist. There are many.

For two hundred years doctors accepted adhesions that result from peritonitis as unconquerable. Yet today any surgeon competent to open the abdomen can restore to normal health any person afflicted with any degree of intestinal adhesions and obstructions due to the adhesions across the small bowel.

In all branches of our science we are pleased to see that what is impossible today will be routine tomorrow. Every indication points to the fact that there can be no limited horizon in our science. With the extension of these benefits, there has come about a sharper delineation of the specialties

and a tendency in the larger city centers for men to limit themselves to their chosen fields. There has been a constant, growing acceptance of these limitations with descriptive terminology, and with this acceptance has come the strange belief that each man should stay within the narrowed confines of his chosen specialty.

With all good there may be something not so good. In the early days of surgery patients traveled great distances to the specialist who could do the unusual. Now that distance has been shortened to the length of a taxi ride, almost throughout the land. As that distance becomes shorter, a notion is taking root in the minds of physicians that it is right for men to be so limited and that it is right for the profession to be so policed that only the specialist is accredited.

We are seeing today increasing numbers of recognized specialties, with the provision accepted that no man should practice in more than one specialty, until it is rather difficult to find a physician who can give his patient a well-rounded service. We read not long ago of the absurd extent to which union practice in Hollywood has made it impossible for one man to move a chair and a vase of flowers on the same stage setting. It is perfectly obvious that any man able to come to work could do both jobs satisfactorily. In medicine, there are many overlapping fields and there are many men so constituted that they can give excellent care in several specialty fields of service. In the rural communities, and they make up the great bulk of this great land, doctors today must serve their communities as completely as my grandfather did, and to the limit of the knowledge of their science, just as he did. It is not right that these men, necessary as they will be for decades to come, should stand unrecognized, uncertified or unaccredited.

The American Boards of the Specialties and the various exclusive societies of the specialties have sprung from the original desire of men to limit their wisdom. They have sprung from the hope of men to improve their ability to attack disability. Two tangents from this concert of desire and hope have brought into necessity a kind of action by each state medical association that must be taken soon if we are to remain in control of our own undisturbed destiny. The state association must certify the doctors of the state, for several good and timely reasons.

First, we find that the hospitals through which physicians are bringing to Americans the chance of life where heretofore it did not exist are being welded into one monopolistic and centrally controlled hospital association. A ghost constitution has been sent to every hospital that wants accrediting or certification and the doctors must sign this constitution and agree to abide by it if they want their patients to be served by the hospital. The American College of Surgeons denies that it can exert compulsory control in any degree over doc-

tors. The American Medical Association very recently denies its members any succor from the compulsory attendance at hospital staff meetings which the American College of Surgeons says they do not demand, but which the doctors must attend if the hospital in question is to be certified by the American College of Surgeons so it can get its interns. It is quickly apparent that extra-legal controls over physicians and nurses are being exerted by national organizations who deny that control, and who offer no retreat from their plans.

Secondly, we have ever in front of us socialistic medicine, which can be most easily brought into being if our hospitals and societies are nationally organized so that they command obedience from the doctors through one or another subterfuge, and so curtail their services to the public.

In a republic with its democratic form of government, it seems right and logical that state control be retained if we are to keep our state units identifiable. In the medical profession, the state medical association conforms in parallel to the state political organization. It is perfectly obvious, therefore, that an official certification of all doctors at the state medical association level is a necessity, and urgently so. It is necessary that physicians will not be limited arbitrarily so that their community suffers. It is not necessary that physicians should conform to a single specialty, since that is an impossibility in many communities and since many men do excellent work in many fields. I know physicians in Indiana who hold diabetic clinics regularly, serve their patients as pediatricians excellently, whose obstetrical statistics are admirable, and at the same time whose work in abdominal surgery keeps their patients perfectly satisfied and is above reproach from men like me who specialize. Any limitation of the work of men of this kind would be purely artificial, entirely impractical and probably entirely illegal. It is within the province of the state medical association to stamp these men with a protective official approval.

In certifying its own members, a state medical association will be a little closer to home, and I can see that a more practical measure of ability will be placed upon a man than that of the childish reliance upon written examination. A school teacher may believe in the infallibility of such an examination. Most of us who have passed on some decades away from the school teacher know that all too often, in fact more often than not, the honor roll pupil and high-grade student is not the greatest contributor to the knowledge in our science or to the welfare of our patients. We do not observe a parallel between the written examination of the medical student and the excellence of that man's skill or work or service to his community in later years.

The basic sciences were the foundations for the beginning of medical learning. In a way, a study of the basic sciences was a bit of mental gymnastics that trained the embryo doctor into a way of

thinking. Today, most of the boards and too many state licensing bureaus put these same basic sciences, these same elementary studies, as a stumbling block in the path of accrediting every physician. This seems to me to denote the sterility of imagination on the examiners' part, or perhaps some unfamiliarity with the practical aspect of the subject in which the applicant is being examined. We must not be forced to take time off in order to go backward.

Official certification by the state medical association should be secured through the county society, subject to study at the state association level. The mechanism for all this already exists in both the county and state organizations.

There may be a better way of bringing about certification of all doctors who are members of their state medical association, but as a starter let us suppose that any doctor makes application through his county medical society to the state association for certification in his field of daily practice. This, as you see, has no reference to the specialties listed as accredited elsewhere. The council of his county society then takes his application under consideration.

If the applicant lists himself as able to do more than the members of his county society know him to be fitted to do, they may pass his application on, with their disapproval, to the state council, giving their reasons. They might accept him in the fields in which they know him to be fit and to that extent recommend his acceptance. Either way there is a censorial check by the county council upon the man whom they know so well.

The state association council might take issue with the acceptance or denial as received from the county society. They might act against a county decision for cause.

Obviously, two things can go wrong. A county council may approve an unfit man or may deny a fit man, all through the action of personal likes and dislikes. This simple mechanism includes a chance of appeal so that if a doctor thinks he has not met justice at the hands of his county society, he can go next higher to the state association to prove his ability that has been denied him locally. Likewise, the county council is in a position to defend its action in front of the state association so that within the state association the route to justice is assured to both the physician to be certified and the county medical society who takes the first official action in this certification.

Obviously, under the setup of organization of the medical profession of the United States, if enough state associations see the light, eventually the A.M.A. would be the national and final body to which appeal might be made and justice assured all parties.

In a mechanism of certification of this sort there will be no interference with the Boards of the Specialties as they are presumably formed of entirely voluntary applicants. As the efficiency of

local certification develops through use and understanding of its use, the accrediting power of the state medical association can and should become the sole official determining authority in the profession that keeps within the profession all control of the profession and its members. Anything else is entirely undesirable in a democratic country.

In Indiana a late decision of the Appellate Court has suggested that the county society is the unit of organization best adapted to certifying doctors and qualifying them as fit or unfit in their desired fields of work. Why should the courts be forced to show us the right way?

If we do not keep within our association the authority for certifying ourselves, that authority will be assumed by an outside organization and we will be subject to its control. As yet there is no legal basis for this control, even though it is in action today and is producing disturbance and dissension within the ranks of doctors that must be settled. The time, now, is late. The mechanism for control of ourselves is in existence through the loose organization of county societies, state associations and American Medical Association. If we doctors establish officially the satisfactory and democratic form of control mentioned, then there

can be official recognition and use of this authority if need arises by the army, the government, socialist bureau or other unanticipated regimenting control over doctors. Then there might be preserved that unique thing in the history of medicine, the American doctor.

The physician alone, through his democratic organization of county society and state medical association, can keep at home fair and just control over his own destiny. It must be done officially if authority is to be established. If it is not done, that authority will be granted into other hands and the doctor will be serving without adequate representation. He will be attempting to traverse the deep blue sea of the unknown in pathology that lies ahead, hampered by the devil of regimentation riding his shoulders. Let the doctors of Indiana show the courage of confidence in themselves and so pioneer this very necessary step toward certification of all American doctors through a practical, efficient, democratic means that is subject to reasonable appeal and sensible control. Will the counties or the state do it first; or will we run, bleating like sheep, over the edge of the precipice down into bureaucratic regimentation?

—Dr. Thomas B. Noble, Jr.

U. S. ATOMIC ENERGY COMMISSION SEMINAR ON DISPOSAL OF RADIOACTIVE WASTES

A number of leading members of the sanitary engineering and waterworks engineering profession attended a two-day seminar on disposal of radioactive wastes, in Washington, D.C., January 24-25, at the invitation of the U. S. Atomic Energy Commission. This seminar is part of a continuing effort on the part of the Commission to maintain closer liaison with public health and safety officials on mutual problems arising out of the national atomic energy program. Such liaison is an aspect of the program for dissemination of technical and scientific information on atomic energy with which the Commission is charged under the Atomic Energy Act of 1946.

David E. Lilienthal, chairman of the Atomic Energy Commission, pointed out that the problems of radioactive waste disposal and other atomic energy problems must be discussed from the viewpoint that "We have to learn to live with radiation. Handling the waste disposal problem is a part of learning how to live with radiation. The way we have learned to live with unfamiliar things before was to learn as much as we could about them; not to escape from things by emotional outbursts. Radiation is just as much a natural phenomenon as anything else. The fact that we have by intelligence multiplied it does not change that fact. I am sure that just as we were able by our intelligence to conquer other things, we will conquer this as well."

Among the topics discussed were the types of activities in the national atomic energy program leading to the production of radioactive wastes; the effects, controls, tolerances and methods of measuring radioactivity; the production, distribution, use and controls of radioisotopes; health problems in atomic energy activities; current methods for disposing of gaseous, liquid and solid radioactive wastes; and an appraisal of sanitary engineering problems in the atomic energy industry.

In discussing health problems in atomic energy activities, Dr. Shields Warren, director, Division of Biology and Medicine, AEC, indicated that it is possible to detect radioactivity at levels far below those dangerous to humans and that the problems dealt with are not unknown hazards. Radiation acts in two general ways, Dr. Warren said. External radiation comes from outside the body from the x-ray tube or from a source of radium or from an atomic pile. So far as external radiation is concerned, there is no hazard with proper shielding and proper application of known techniques of waste disposal. Internal radiation comes from radioactive materials which are absorbed by the body, having entered through the lungs or gastro-intestinal tract. To prevent radioactive materials from being absorbed by human bodies is the prime objective of the radioactive waste disposal program.

Medical Panorama by the ASSOCIATE EDITOR

In a speech at the opening of the 70th Annual United Hospital Fund Campaign, New York City, General Eisenhower stated that federal encroachment on the private practice of medicine

"WOULD DO MORE TO ADVANCE STATISM AGAINST DEMOCRACY THAN ANYTHING THAT THE RUSSIANS OR THE COMMUNISTS ARE DOING."

No one can say that General Eisenhower has not had ample opportunity to compare other systems with our own American style. It is heartening to hear such sentiments from a non-medico of proved good sense and judgment.

MORE ITEMS FROM THE BUREAUCRATS

The noble experiment in English medicine continues to yield interesting sidelights upon the vagaries of its operation through the medium of the reports of "Question Time" in Parliament, as printed in *The Lancet*. The following are from the December 18, 1948, number. While one item happens to concern dentists rather than physicians, the implications for either profession are clear enough. Read these and see if you still feel the least compunction about paying the A.M.A. assessments—if, indeed, you ever felt any.

"Dentists' Remuneration"

"Mr. H. G. MCGHEE asked the Minister what alterations he proposed to make in the remuneration of dentists under the National Health Service.—Mr. BEVAN replied: With the dental associations I am undertaking a full review of our present translation of the Spens Committee into fees for services. Meanwhile, as it is obvious that some dentists are earning far more than that committee ever contemplated, I am adopting a temporary arrangement whereby fees are reduced by half after a dentist reaches an income of £4800 gross—or £1000 in excess of the point at which the Spens committee said the risk of bad dentistry began. Doctors already have a limit, in the number of patients allowed on their lists."

Specialists' Domiciliary Visits

"Mr. L. W. JOYNSON-HICKS asked the Minister whether he was aware that medical specialists were, under the operation of the National Health scheme, limited to making a total of 25 visits per quarter in a given area upon patients; and what arrangements there were for the treatment of the patients in that area when the specialist had fulfilled his schedule.—Mr. BEVAN replied: There is no limit on visits. Remuneration has a provisional ceiling for each quarter while longer term arrangements—which will date back—are being worked out. The situation in the last part of the question can be considered if and when it arises."

Apparently our Buckeye colleagues suffer from some of the same shortages as Hoosier physicians, as shown by the following excerpts from an article on "Positions in Doctors' Offices" by G. L. Sackett, M.D., and H. Van Caldwell, executive secretary, in the *Bulletin of the Academy of Medicine*, Cleveland, Ohio:

"The growing complexity of medical practice, with its increasing emphasis on laboratory procedures and the use of diagnostic apparatus, is changing the picture of the doctor's office and creating new problems in the selection of qualified personnel . . .

"Within the past few decades, a new type of school has sprung up in this country offering training for 'Doctor's Assistants' or 'Medical Assistants.' Students in such schools are offered training in bookkeeping, typing, stenography, laboratory procedures, and the care of patients. They may or may not be offered beginning courses in physiology, bacteriology, etc. These are private schools, often operated by physicians or employing physicians and nurses as instructors. Some of these schools clothe their students in a uniform somewhat approximating the nurse's uniform. Many persons, including students and physicians solicited for employment, have indicated that they believed the graduates of such schools were trained technicians. No evidence is available to indicate that this training entitles them to such a belief. . . .

"To seek further light on this phase of the subject, the Bulletin Committee, with the approval of the Board of Directors, early in the summer mailed to the Academy members a questionnaire to ascertain, if possible, what type of education they expected applicants for positions to offer. After discarding all answers in which physicians confused the duties of an office assistant with those of a qualified technician or nurse, the Committee summarized the remaining 275 answers . . .

"Many members took the opportunity to stress what the Committee had assumed, that intelligence and personality counted first in the selection of an assistant. An entire paper could be written on this subject, with emphasis on the part an assistant plays in patient relations and public relations, but such was not the object of this study.

"From the answers as submitted, the Committee can only make the following conclusions and comments:

- There is little evidence to indicate the need for technical training of doctor's assistants.
- If such a need does arise, *all* schools training girls who enter the employment of physicians might well consider establishing courses in simple laboratory procedures under proper supervision.
- The doctor still finds as his first need, an intelligent, personable assistant trained much as the employees in commercial or other professional offices."

Ain't it the truth, mister? We mean paragraph "c," where it says, "intelligent, personable." From there you can go on and on, but if you don't start there, you'll simply mark time.

News Notes

Two physicians were appointed recently by Governor Schricker as new members of the Indiana State Board of Health. They are Dr. Russell W. Lavengood, of Marion, and Dr. Harry P. Ross, of Richmond. Dr. J. T. Oliphant, of Farmersburg, was reappointed to the board.

Dr. Charles J. Aucreman, of Muncie, has joined the staff of the Caylor Nickel Clinic in Bluffton, where he will serve as head of the ophthalmological department. He is a graduate of the Washington University School of Medicine, in St. Louis, and spent his internship at the Methodist Hospital in Indianapolis. He also served a year's residency in ophthalmology at the Cleveland City Hospital.

Dr. William G. Bannon, formerly of Kokomo, has received an appointment as a resident in internal medicine at the Mayo Clinic, for a period of three years, beginning July 1. He is a graduate of the Indiana University School of Medicine in 1945, and spent his internship at Indianapolis General Hospital. Following his discharge from the Army last June, Doctor Bannon took a residency in medicine at the Nichols General Hospital in Louisville.

Dr. Jack D. Cartwright has opened an office for the practice of medicine and surgery at 806 Madison Street, in La Porte. A graduate of the Northwestern University School of Medicine in 1947, he served his internship and residency at Wesley Memorial Hospital in Chicago.

Dr. Louis Calli, physician and surgeon from Massena, New York, has opened a clinic in North Vernon.

Dr. Alvin F. Cohn, who has practiced medicine in Clinton for the past three years, has moved to Franklin, where he is practicing part time while serving as a resident in anesthesiology at Indianapolis General Hospital.

Dr. Robert W. Donnelly, of Sullivan, has accepted a position on the medical staff of the Arabian American Oil Company Hospital in Dhahran, Arabia, where he will remain for at least two years. He is a graduate of the Indiana University School of Medicine in 1941, and had served for four years with the U. S. Army Medical Corps in the North African and European Theaters. He began his practice in Sullivan in December 1945, where he has practiced until the present time.

Dr. Edwin N. Kime, professor of Anatomy, and Dr. Carl H. McCaskey, chairman of the Department of Otolaryngology, at Indiana University School of Medicine, gave a course in Applied Anatomy and Cadaver Surgery of the Head and Neck for the Los Angeles Research Study Club in Otolaryngology. The course began January 28 and lasted until February 2. Dr. McCaskey presented a paper before that group, on January 28, on "Surgery in Laryngeal Disease."

Dr. Raymond Stover, formerly of Francesville, has moved to Lewiston, Idaho, where he will practice.

Dr. Charles A. Hufnagel, formerly of Richmond, was named as one of the nation's ten outstanding young men of 1948 by the United States Junior Chamber of Commerce. He was chosen in the field of medicine for his work in surgery of the heart and aorta. He formerly practiced surgery in Richmond, and is at present instructor in surgery at the Harvard Medical School, in Boston.

Dr. Richard C. Swan, of Anderson, has been appointed medical director of the Delco-Remy Division of General Motors in Anderson. He will direct the health activities of the division's nine plants, which employ approximately 12,000 persons. Doctor Swan has been plant physician for the Allison Division of General Motors since 1943.

Dr. Rolfe A. Heck, who has been practicing in Oxford for the past year, has opened an office for the practice of medicine in College Corner. He is a graduate of the Hahnemann Medical College and Hospital in Philadelphia, where he also served his internship.

Announcement of the marriage of Dr. Hallie Isabel Morgan to Dr. Murray Stuart Lauder at Kingwood, West Virginia, on December 22, 1948, was recently made. Dr. Morgan, a member of the association from Hendricks County, where she practiced in 1941-1943, is now Director of Maternal and Child Health of the State Department of Health, with offices in Charleston, W. Va. Dr. Lauder, a native of Canada and a graduate of Queens University, is a chest physician engaged in tuberculosis control work with the West Virginia State Department of Health. The couple will reside in Charleston.

Announcement has been made recently of the appointment of **Dr. James J. Hoover**, of Terre Haute, as a member of the Board of Trustees of the Central State Hospital, at Indianapolis. This appointment was made by Governor Schricker.

Dr. Robert P. Jay, of Indianapolis, is now practicing obstetrics and gynecology in Honolulu, where he is associated with **Dr. Lyle G. Phillips**.

A 1940 graduate of the Indiana University School of Medicine, **Dr. John D. Stepleton** is now located at Richmond, where he is engaged in the practice of clinical pathology at Reid Memorial Hospital.

Dr. Robert Kammen, who graduated from the Indiana University School of Medicine in 1943, has opened an office for the practice of medicine at 3202 West 16th Street, in Indianapolis.

Dr. John E. Meihaus, of Indianapolis, is serving a residency in internal medicine at St. Vincent's Hospital in Los Angeles, following his recent release from the Navy. He is a 1945 graduate of the Indiana University School of Medicine.

Having completed an extensive postgraduate course in the East, **Dr. James H. Gosman** is now located at 407 Hume-Mansur Building, in Indianapolis, for the practice of dermatology and syphilology. A 1938 graduate of Indiana University School of Medicine, Doctor Gosman served for five years in the United States Army.

Dr. Robert King, of Hammond, has moved to Cedar Lake, where he will establish a practice. For the past three years he was associated with Drs. N. K. Forster and Dr. A. C. Remich, in Hammond. Doctor King graduated in 1944 from the Loyola University School of Medicine, in Chicago, and interned at Cook County Hospital there.

Dr. Robert H. Rang has announced the opening of an office in Washington for the practice of surgery. A graduate of the Indiana University School of Medicine in 1940, he served his internship at the Methodist Hospital in Indianapolis, where he also served for one year as a resident in surgical pathology. Following this he began serving a fellowship in surgery at the Mayo Clinic, which was interrupted by the war. Doctor Rang served for three years in the medical corps of the United States Army, two years of which were spent overseas in the European theater of war. Upon his release from the Army, he returned to the Mayo Clinic to complete his fellowship.

The 1949 Michigan Postgraduate Clinical Institute is scheduled for the Book-Cadillac Hotel, in Detroit, on March 23, 24 and 25, 1949. Forty-nine eminent physicians and surgeons from the United States and Canada will appear on the program. On March 26, following the Institute, a "Heart and Rheumatic Fever Day" will be held. Specialists in the fields of cardiovascular disease will present their latest findings at this meeting. All members of the Indiana State Medical Association are invited to attend.

The National Society for the Prevention of Blindness will hold a three-day national conference, March 16, 17 and 18, 1949, at the Hotel New Yorker, New York City. The theme of the meeting will be "The Battle Against Blindness—The Next Forty Years," and the following subjects will be discussed: Eye Problems in Middle Life; The Eyes of Children and Young Adults; Vision in Industry; Medical Advances in Sight Conservation; Glaucoma—A Community Problem.

Persons directly or indirectly concerned with eye health and safety will find this conference of interest. Details concerning the program may be obtained by writing directly to the Society at 1790 Broadway, New York 19, N. Y.

The American Academy of General Practice announces a panel of twenty outstanding clinical teachers who will present lectures at the first Annual Scientific Assembly, to be held in Cincinnati at the Netherland Plaza Hotel, March 7, 8 and 9. The following doctors will speak:

Walter C. Alvarez, Rochester; M. Edward Davis, Chicago; Paul A. Davis, Akron; John E. Dees, Durham; Charles A. Doan, Columbus; Joseph A. Freiberg, Cincinnati; Lowell S. Goin, Los Angeles; Francis C. Grant, Philadelphia; Tinsley R. Harrison, Dallas; Robert A. Kehoe, Cincinnati; John A. Kolmer, Philadelphia; Karl A. Meyer, Chicago; Norman F. Miller, Ann Arbor; Francis D. Murphy, Milwaukee; Franklin D. Murphy, Kansas City; Walter J. Reich, Chicago; Howard A. Rusk, New York; Tom D. Spies, Birmingham; Philip Thorek, Chicago; Herman G. Weiskotten, Syracuse.

Scientific sessions of the Assembly will be held on all three days of the meeting. The program is a broad one, selected by general practitioners, for general practitioners, and featuring topics of down-to-earth value to the man in general practice.

The Academy extends the invitation to attend to all members of the American Medical Association.

For reservations write Subcommittee on Hotels, American Academy of General Practice, 910 Dixie Terminal Building, Cincinnati 2, Ohio.

PROGRAM

The Northern Tri-State Post-Graduate Medical Association**Fort Wayne, April 12, 1949**

REGISTRATION ----- 8:30 A. M.
 WELCOME ADDRESS ----- Orville J. Miller, M.D.
 President, Allen County Medical Society, Fort Wayne
 ADDRESS ----- Don F. Cameron, M.D.

President, Northern Tri-State Post Graduate
 Medical Association, Fort Wayne
 "Surgical Emergencies of the New Born" -----
 ----- Clifford D. Benson, M.D.
 Department of Surgery, Harper Hospital, Detroit
 "Lesser Known Uses of Thyroid Substance" -----
 ----- Robert C. Moehling, M.D.
 Department of Medicine, Harper Hospital, Detroit
 "Surgery of the Thyroid Gland" -----
 ----- George M. Curtis, M.D.
 Department of Surgery, Ohio State University,
 Columbus

"Clinical Pathological Conference" -----
 ----- Bernhard Steinberg, M.D.
 Toledo Hospital Institute of Medical Research, Toledo
 LUNCHEON HOUR: 12 Noon—1:45 P.M.
 "A Doctor Makes a Critical Survey of the Medi-
 cal Profession" ----- Paul R. Hawley, M.D.
 Chief Medical Officer, Blue Cross, Blue Shield
 Commission, Chicago

AFTERNOON SESSION
 "The Psychology of the Chronically Disabled
 Patient" ----- Morton A. Seidenfeld, Ph.D.
 Director, Psychological Services, National Founda-
 tion for Infantile Paralysis, New York
 "The Study of the Effects of Androgens on the
 Cardiovascular System" ----- James B. Berardi, M.D.
 Chief Medical Officer, Veterans Administration
 Regional Office, Chicago
 "Office Treatment of Allergic Patients" -----
 ----- George L. Waldbott, M.D.
 Harper Hospital, Detroit
 "The Reason for Post Graduate Medical Educa-
 tion" ----- Howard H. Cummings, M.D.
 Chairman, Post Graduate Medical Education,
 University of Michigan, Ann Arbor

If hotel reservations are desired, please notify Dr.
 Don F. Cameron, Wayne Pharmacal Building, Fort
 Wayne, Indiana, or Dr. William Henry Gordon, 1102
 David Whitney Building, Detroit, Michigan.

The International Congress on Rheumatic Dis-
 eases will be held in New York City from May 30
 to June 3, 1949.

The Congress, sponsored by the International
 League against Rheumatism, is expected to bring
 together the world's leading authorities on rheu-
 matic diseases, including arthritis. These diseases,
 prevalent throughout the world, cause tremendous
 disability and economic loss, paralleling that of
 other major crippling and killing chronic diseases
 such as tuberculosis, diabetes, cancer, or heart
 disease.

The American Rheumatism Association, which is
 serving as host for the Congress and providing
 most of the financing, hopes that the meeting will
 result in a renewed and better integrated world-
 wide attack on rheumatic diseases. The five days
 of scientific discussions are being planned to empha-
 size that only a combined world-wide attack by
 scientists trained in the biological, biophysical,
 biochemical, and clinical disciplines will realize the
 full potentialities of modern science in combatting
 these diseases.

ELEVENTH COUNCILOR DISTRICT MEETING

The Eleventh Councilor District Medical Society
 will meet in Logansport on May 18. The Cass
 County Medical Society is sponsoring the pro-
 gram and arrangements for this meeting. Speakers
 on the program will be: John R. Brayton, M.D.,
 dermatological consultant for the VA hospitals in
 Indianapolis; J. L. Arbogast, M.D., director of Clin-
 ical Laboratory, Indiana University; R. E. West-
 moreland, M.D., chief of Medical Service, VA hos-
 pital, Cold Springs Road, Indianapolis; L. T. Cog-
 geshall, M.D., chairman, Department of Medicine,
 University of Chicago, Frank Billings Medical
 Clinic.

The American Board of Ophthalmology wishes
 to announce that it does not evaluate, approve,
 or disapprove any ophthalmic residency toward ful-
 filling the requirements for candidates for board
 examinations. Any candidate who qualifies for the
 board examination and completes the prerequisites
 as outlined in the booklet of information will be
 accepted. A copy of this booklet of information
 will be accepted. A copy of this booklet can be
 obtained from the Secretary of the American
 Board of Ophthalmology, 56 Ivie Road, Cape Cot-
 tage, Maine.

34TH ANNUAL MEETING OF INDUSTRIAL
PHYSICIANS AND SURGEONS

The Industrial Physicians and Surgeons of the
 United States and Canada will hold their 34th
 annual meeting at Detroit, Michigan, April 2 to 9,
 1949, with headquarters at the Book-Cadillac and
 Statler Hotels. Participating groups are the:
 American Conference of Governmental Industrial
 Hygienists; American Industrial Hygiene Assoc-
 iation; American Association of Industrial Den-
 tists; American Association of Industrial Nurses.

The week-long program will feature (1) Surgical
 Clinics at the Henry Ford and Harper Hospitals,
 (2) Scientific sessions on such timely subjects as
 the problems created by atomic radiation, cardio-
 vascular diseases among the employed, alcoholism
 in industry and toxicities of industrial substances
 such as beryllium, agricultural chemicals and rare
 metals and (3) special sessions for physicians in
 steel manufacturing and heavy industry, in rubber,
 petroleum and chemicals in coal mining and metal
 mining.

Other features are the arrangements for plant
 tours along the assembly lines of the great auto-
 mobile companies and through the plants of many
 of Detroit's famous manufacturies. All physicians
 and surgeons, industrial hygienists, industrial
 nurses and others interested in industrial health
 are invited to attend.

AIR POLLUTION STUDY BEGUN

One of the most comprehensive studies of air pollution ever undertaken in the United States was begun on January 10 at Donora, Pennsylvania, scene of a smog disaster where 20 persons recently died.

Before a full-scale study of the Donora disaster could be started, it was necessary to send a task force into the area to make preliminary observations and decide on a course of action. The task force study has been completed.

The larger study will take in the entire Donora-Webster area in the Monongahela Valley. The study group includes two or more physicians, four nurses, a dentist, a medical technician, six engineers, and two statisticians. All are specialists in industrial hygiene.

ENDOCRINE GLAND RESEARCH

Dr. R. E. Dyer, Director of the National Institutes of Health, has announced that a co-winner of the 1947 Nobel Prize for physiology and medicine, Dr. Bernardo A. Houssay, of Argentina, has arrived in this country to do research for three months at the Institutes in Bethesda, Maryland, as a Special Research Fellow of the Public Health Service, Federal Security Agency.

The research will be concerned with fundamental problems of endocrine gland regulation and balance and the relationship between the endocrines and metabolism. With two colleagues from Argentina, Drs. V. G. Foglia and Carlos Martinez, who are also on Public Health Service Research Fellowships, Dr. Houssay will work in laboratories of the Experimental Biology and Medicine Institute of the National Institutes of Health.

The American Academy of Allergy, in cooperation with the University of Georgia, will sponsor an orientation course in allergy from March 7 through March 11, 1949, at the University Medical School in Augusta, Georgia. This course is under the direction of Dr. Leo H. Crip, assisted by other Fellows of the American Academy of Allergy, and a distinguished faculty.

The course is intended for internists and general practitioners, dermatologists, rhinologists and nose and throat men. The course content will be exceedingly practical and directly applicable to the practice of most physicians doing general medicine. It will include lectures and clinical demonstrations on allergens, hay fever, bronchial asthma, diagnosis and treatment, diagnosis, etiology, pathology and immunology of allergy, allergic rhinitis, atopic dermatitis and other significant manifestations in the field.

Enrollment is open to anyone interested and the fee is fifty dollars. Applications and inquiries should be addressed to the Executive Office of the Academy, 208 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

INDIANA MENTAL HYGIENE SOCIETY

The Indiana Mental Hygiene Society was organized in Indianapolis on February 10, the purpose of which is to establish an alliance between psychiatry and the lay public. They plan to organize units in each county in the state. Where local societies are now in existence, they will be invited to integrate their activities with the state organization. Officers of the new society are: president, Edward F. Gallahue; vice-presidents, Philip B. Reed, M. D., and Rev. E. Burdette Backus; treasurer; S. P. Clay, Jr.; secretary, Mrs. Alice H. Sanders, and executive secretary, Mrs. Letta I. Shonle, all of Indianapolis. Other Board members are: Murray DeArmond, M.D., Frank H. Fairchild, C. Oliver Holmes, Professor Charles C. Josey, and George Thorman, all of Indianapolis; and Marvin F. Greiber, M.D., of Muncie. Groundwork for the new society was laid in committee meetings arranged by Dr. E. Vernon Hahn and the Reverend Mr. Backus, both of Indianapolis.

DR. JOHN W. FERREE NAMED PUBLIC HEALTH DIRECTOR OF AMERICAN HEART ASSOCIATION

Dr. John W. Ferree has been named Director of the Public Health Division of the American Heart Association, it was announced recently by A. W. Robertson, Chairman of the Board.

Dr. Ferree will direct the development of public health programs for the American Heart Association and will assist local heart associations in expanding and maintaining effective cardiac services in communities throughout the United States. He will supervise the Association's field staff now engaged in community organization and program development.

The formation of additional affiliated heart associations and the expansion of community services comprise an important objective of the American Heart Association's 1949 National Campaign, from February 7 to 28. A total of \$5,000,000 is being sought for a three-way program of research, education and community service.

Dr. Ferree has a wide background in public health and social hygiene. For two years prior to his present appointment, Dr. Ferree has been Associate Director of the National Health Council, in New York, and earlier was Director of Educational Services for the American Social Hygiene Association.

Dr. Ferree, a native of Indiana, was educated at the University of Pennsylvania and the Indiana University School of Medicine. He entered the public health field in 1936 and from 1940 to 1942 was State Health Commissioner of Indiana. In the latter years he served as Secretary of the Association of State and Territorial Health Officers. During the war he served as Commander in charge of the VD Control Section, Division of Preventive Medicine, Bureau of Medicine and Surgery, Navy Department, Washington, D.C.

FIRST WOMAN PHYSICIAN CENTENNIAL CONVOCATION

One hundred years ago, quiet and determined Elizabeth Blackwell overcame the barrier of sex to become the country's first woman doctor of medicine.

On January 23 Hobart and William Smith Colleges celebrated the awarding of a medical degree to Miss Blackwell by Geneva College (forerunner of Hobart) with a centennial convocation.

Citations were presented to twelve of the world's outstanding women doctors from the United States, Canada, England and France.

Mrs. Eleanor Roosevelt opened the convocation with a salute to the 7,500 American women doctors and their confreres throughout the world.

The citations were conferred by Dr. Alan W. Brown, president of Hobart and William Smith Colleges, with a response by Dr. Priscilla White of Boston, a specialist in diabetes and one of the twelve honored.

The other doctors, chosen by poll of the deans of medical schools of the United States and Canada, and through the embassies of England and France, were:

Dr. Florence R. Sabin, of Denver, for contributions to medical research.

Dr. Alice Hamilton, Hadlyme, Conn., for pioneer work in industrial toxicology.

Dr. Helen B. Taussig, Baltimore, noted "blue baby" specialist.

Dr. Martha May Eliot, Washington, associate chief of the U. S. Children's Bureau.

Dr. Gerty T. Cori, Webster Groves, Missouri, Nobel prize winner.

Dr. Margaret D. Craighill, Topeka, Kansas, for work in the field of military medicine.

Dr. Helen MacMurchy, Toronto, Ontario, Canada, former chief of the division of child welfare in the department of health, Dominion of Canada.

Dr. Elise S. L'Esperance, New York, for work in cancer prevention and leadership of women in medicine.

Dr. Helen M. M. MacKay, London, internationally known pediatrician and first woman to be elected to the fellowship of the Royal College of Physicians.

Dr. Therese Bertrand Fontaine, of Paris.

Elizabeth Blackwell was born in Bristol, England, February 3, 1821, the third daughter in a family of nine brothers and sisters.

The family emigrated to America and eventually settled in Cincinnati. There Elizabeth decided to become a doctor of medicine.

She raised money for her education by teaching. A Quaker doctor in Philadelphia, the Rev. John Warrington, enabled her to fulfill the requirement of three years' study under a physician prior to two courses of medical lectures.

The barriers against her sex in the medical field were so great that Dr. Warrington suggested she go to Paris and enter school disguised as a man.

Seventeen medical schools refused her admission. Undaunted, she wrote a dozen smaller schools. Refusals came from 11. Then came a letter dated October 20, 1847, from the medical department of Geneva (N. Y.) College.

In Geneva she was an object of disdainful curiosity. On the streets she was greeted with jeers and catcalls from rowdies. Women crossed to the other side of the street.

At the end of the course in January, 1849, Elizabeth ranked first in the class, and her degree was awarded January 23 by school President Benjamin Hale.

POSITIONS OPEN FOR MEN NURSES

More positions are open for men nurses today than there are applicants, according to the American Nurses' Association, which, in connection with the Diamond Jubilee of Nursing marking the 75th anniversary of the profession in this country, has launched a campaign to enlist the entire nation in a united effort to overcome the present nursing shortage.

There are approximately 9,000 male nurses in America today, the ANA reports, but the "general demand for professional nursing care has so far outstripped the growing number of nurses, that there is ample opportunity for men as well as women nurses."

Public Health, industrial and psychiatric nursing are especially suited for enterprising men who wish to enter nursing as a profession, according to the ANA.

COMING MEDICAL MEETINGS

Indiana State Medical Association, Indianapolis, September 26, 27, 28, 29, 1949.

American Medical Association, Annual Session, Atlantic City, June 6, 7, 8, 9, 10, 1949.

American Academy of General Practice, March 7, 8, 9, 1949. Cincinnati. Mac F. Cahal, 231 W. 47th St., Kansas City 2, Mo.

American Association for Thoracic Surgery, New Orleans, March 29, 30, 31, 1949. Dr. Brian Blades, George Washington University Hospital, Washington, D.C., Secretary.

American College of Physicians, New York City, March 28-April 1, 1949. E. R. Loveland, M.D., 4200 Pine Street, Philadelphia 4, Executive Secretary.

American Congress of Physical Medicine, Netherland Plaza, Cincinnati, September 6, 7, 8, 9, 10, 1949.

American Goiter Association, Madison, Wisconsin, May 27, 28, 1949. Dr. T. C. Davison, Atlanta, Georgia.

International Congress on Rheumatic Diseases, Waldorf Astoria, New York City, May 30-June 3, 1949. Dr. Ralph Pemberton, 1901 Walnut St., Philadelphia 3.

Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, March 23, 24, 25, 1949. Dr. L. Fernald Foster, 2020 Olds Tower, Lansing 8, Michigan, Secretary.

National Society for the Prevention of Blindness, Hotel New Yorker, New York City, March 16, 17, 18, 1949. Write the Society, 1790 Broadway, New York 19.

Northern Tri-State Post-Graduate Medical Association, Fort Wayne, April 12, 1949. Dr. Don F. Cameron, Wayne Pharmacal Building, Fort Wayne.

INFLUENZA EPIDEMIC

"The influenza epidemic now spreading over Europe may reach this country, but so far there is no indication of this," Dr. Leonard A. Scheele, Surgeon General of the Public Health Service, Federal Security Agency, said recently.

"Unlike the disastrous epidemic of 1918, the present epidemic is mild in character and is causing few deaths.

"In the past it has been noted that most deaths in this disease result from secondary bacterial infection. Thanks to extensive medical research in recent years, we now have such chemotherapeutic materials as penicillin and the sulfa drugs, which can control most of the bacteria that act as secondary invaders.

"The Public Health Service and the medical departments of the Army, Navy, and Air Force are in constant touch with the situation both here and abroad through the Influenza Information Center at the National Institutes of Health and otherwise.

"There have been no significant outbreaks of influenza in this country so far this winter; in fact, the incidence of this disease reported during the past half year is lower than that reported for the corresponding period in every other year since 1945. The figure for the period from July 31, 1948, to January 8, 1949, is only 36,278 cases reported, as compared with 362,248 three years ago. Two years ago it was 32,975; one year ago, 36,696."

The Influenza Information Center has asked all state and local health officers, as well as state and local communicable disease control officers, to report promptly every local or regional outbreak of influenza in this country.

If a significant outbreak were reported in a given community, the Influenza Information Center would alert diagnostic laboratories in the region, asking them to carry out serological tests on patients for the presence of antibody against the influenza virus. Certain laboratories would also be asked to assign to the affected community a team of investigators experienced in the techniques of isolating the virus. As soon as a new strain of virus was isolated, it would be sent at once for a complete antigenic analysis to the Strain Study Center of the Influenza Commission, Army Epidemiological Board, at Long Island College of Medicine, Brooklyn, New York. Appropriate strains of the virus which had been isolated would be considered for possible inclusion in commercial vaccine.

Fifty-six diagnostic laboratories are participating in the program.

The decennial meeting of the United States Pharmacopoeial Convention will be held at the Hotel Statler in Washington, D.C., on May 9 and 10, 1950. In compliance with the provisions of the Constitution and By-Laws of this organization, the several bodies which are entitled to representation at the 1950 decennial meeting are invited to appoint not exceeding three delegates and three alternates to the meeting. For further information correspond with the secretary, Adley B. Nichols, 4738 Kingsessing Avenue, Philadelphia 43.

**AMERICAN COLLEGE OF PHYSICIANS
POSTGRADUATE COURSES**

The American College of Physicians has arranged a number of postgraduate courses for the spring of 1949. Course No. 4, on "Internal Medicine," will be held March 7-19, 1949, at Massachusetts General Hospital in Boston. James H. Means, M.D., will be the director. The minimal registration is 90, maximal registration is 125. Fees: A.C.P. members, \$60; non-members, \$120.

Course No. 5 will be on "Electrocardiography: Basic Principles and Interpretation," which will be held April 25-30, 1949, at Massachusetts General Hospital, in Boston. Conger Williams, M.D., will be the director. The maximal registration is 25 and the fee for A.C.P. members is \$60; for non-members, \$120.

Course No. 6 will be held April 28-May 1, 1949, at Haddon Hall Hotel, Benjamin West Room, at Atlantic City, with Leo H. Crip, M.D., as director. The course will be on "Diseases Due to Allergic and Immune Mechanisms." The minimal registration is 25; maximal registration 50. For A.C.P. members the fee is \$30; for non-members, \$60.

On May 2-7, 1949, course No. 7, on "Cardiovascular Disease," will be held at Philadelphia Institutions, The American College of Physicians, in Philadelphia. The director will be William G. Leaman, Jr., M.D. Minimal registration is 50, maximal registration 90. Fees: A.C.P. members, \$30; non-members, \$60.

Course No. 8, on "Physiological Basis for Internal Medicine," will be held May 9-14, 1949, at the University of Pennsylvania Graduate School of Medicine, at the University Museum Auditorium, in Philadelphia. Julius H. Comroe, Jr., M.D., will be the director. Minimal registration is 50; fees: A.C.P. members, \$30; non-members, \$60.

Course No. 9, on "Endocrinology," will be held June 13-18, 1949, at Tufts College Medical School, in Boston. Edwin B. Astwood, M.D., is the director; E. W. Dempsey, M.D., and Roy O. Greep, M.D., are the associate directors. Minimal registration is 40; maximal registration, 100. Fees: A.C.P. members, \$30; non-members, \$60.

For detailed information of courses, address E. R. Loveland, executive secretary, The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

ARMY MEDICAL DEPARTMENT OFFICERS TEACH IN CIVILIAN SCHOOLS

In line with the policy of cooperation between the Army Medical Department and civilian medicine, 28 Army Medical Department officers are now serving as part time instructors on the faculties of civilian medical schools.

It is indicative of the "close relationship" growing between Army medicine and civilian medical institutions. General Bliss emphasized the mutual advantages to Army and civilian medicine derived from the interchange of medical knowledge and educational technique which is accomplished by such a cooperative program.

Medical Department officers who serve on the faculties of civilian institutions do so voluntarily, without remuneration and, in many cases, on their own time. The work of these officers is not to be confused with the regular assignment of Medical Department officers as Professors of Military Science and Tactics at those universities where Medical Department ROTC units exist.

The list includes 23 Medical Corps officers, two Medical Service Corps officers, two Dental Corps officers, and one from the Veterinary Corps.

RE-EVALUATION OF VA HOSPITAL EXPANSION

Re-evaluation of the Veterans Administration Hospital expansion program in the light of experience gained in the three years since the end of the war has indicated a need for changes in the program.

Study has shown that estimated needs for hospital beds made during and immediately after the war were considerably larger than actually has proven necessary, although admission policies have been such that more than two out of three patients are admitted for nonservice-connected ailments.

On the strength of developments and based on careful restudy of 64 individual projects not yet under contract, the President has ordered a reduction of 16,000 beds, including temporary and emergency beds. To effect this, VA plans the cancellation of 24 new hospitals and reduction in the size of 14 others.

None of the hospitals is beyond the planning stage. VA currently has 31 new hospitals in various stages of construction.

The new building program will not result in a single service-connected veteran being denied immediate hospitalization.

The change in plans was made after a careful restudy of the VA Hospital program and, even under the curtailed program, the VA will be able to admit an even larger proportion of nonservice-connected patients than at present.

There are no changes contemplated in the present liberal policy of hospitalization.

Principal reasons for cancellation of proposed construction are:

1. Inability of VA to staff fully its present hospitals and a further definite shortage of professional personnel to staff new hospitals;

2. Estimated possible maximum load of service-connected patients is 51,000, leaving more than twice as many other beds available to other veteran patients;

3. Temporary hospitals taken over from the Armed Forces at the end of the war are remaining serviceable beyond original estimates and will not need immediate replacement as had been contemplated;

4. The delay will give VA a full opportunity, in the light of experience with World War II patients, to develop further a program which meets the lasting needs of all veterans.

Mr. Gray pointed out that at present VA has 110,433 beds in its own hospitals, but due to lack of doctors, nurses, technicians and other personnel, operates only 103,533 beds with about 93,000 patients.

ARMY TO CONTINUE CIVILIAN CONSULTANTS PROGRAM TO OVERSEAS INSTALLATIONS IN 1949

The Army Medical Department will continue the Civilian Consultants Program during 1949, Major General Raymond W. Bliss, the Surgeon General, has announced. The program, which consists of sending teams of eminent civilian medical and surgical specialists each month to Army and Navy hospitals in Europe, the Far East, and the Panama Canal Zone, has been so successful that it may be retained as a permanent part of the Medical Departments' operations.

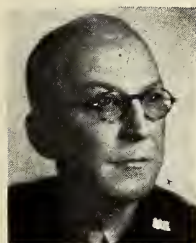
The program was an innovation of World War I. During World War II the system was revived, but greatly enlarged and strengthened. The consultants, all men of recognized professional achievement, were stationed in every theater of operations, as well as in the United States. It was their job to see that medical officers were placed in positions appropriate to their abilities and training and to be available for consultation.

With the cessation of hostilities, the majority of civilian experts who had been in uniform returned to private practice. Due to a shortage of experienced medical officers, General Bliss felt that the younger officers, especially the ASTP graduates, were not receiving the experienced supervision and teaching due them, especially those officers in overseas installations. Accordingly, a team of consultants was sent to Europe in September, 1947, and in 1948 the program reached full development.

Differing from the wartime program, the present mission is to give Medical Department personnel overseas, especially the younger physicians, the benefit of graduate medical teaching, as well as to have the consultants available for consultation and care of patients. In addition, each consultant, on return to the United States, offers recommendations to the Surgeon General.

Deaths

Lacey Lee Shuler, M.D., widely-known orthopedic surgeon of Indianapolis, died suddenly on January 15. He was fifty-six years of age. Doctor Shuler



was a veteran of both World Wars, and spent eighteen months in England as a colonel in the Army Medical Corps during World War II. He became chief of the orthopedic section of the 104th General Hospital unit in England. Doctor Shuler was a graduate of Indiana University School of Medicine in 1919, and was a

former professor and chairman of the Orthopedic Department of the School of Medicine until 1933. He was a member of the American Board of Orthopedic Surgery, the Clinical Orthopedic Society, the American Academy of Orthopedic Surgeons, and the American College of Surgeons. He was also a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Henry William Markley, M.D., of Rochester, died suddenly in his home on February 6, at the age of seventy-seven. He was a graduate of the Hospital College of Medicine of Louisville, Kentucky, in 1901, and had practiced in Rochester for twenty-five years. Prior to that time he had practiced in Redkey. He was a member of the Fulton County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

* * *

William Wirt Eichelberger, M.D., of Evansville, died suddenly on January 12. He was seventy years of age. He graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons in Baltimore in 1904, and had specialized in psychiatry. He was a veteran of World War I, in which he served on the neurological board at Camp Funston, Kansas. He was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Samuel Kennedy, M.D., of Shelbyville, died on February 1, after a brief illness. He was eighty-one years of age. Doctor Kennedy had been active



in state medical association affairs, having served as Councilor of the Sixth District from 1932 to 1946. He had served on the Committee to Study Problems of Quackery and Nostrum Consumption, on a Special Committee on Medical Care of the Indigent, and on the Committee on Industrial Health. Doctor Kennedy grad-

uated from the Medical College of Indiana, in Indianapolis, in 1891, and had practiced in Shelbyville since 1892. He had served as surgeon for the New York Central Railroad for fifty years, and held the same post with the Pennsylvania lines for twenty-five years. He was an honorary member of the Shelby County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Ezra Robert Baldrige, M.D., of Terre Haute, died after a short illness on January 15. He was seventy-five years of age, and had practiced in Terre Haute for fifty years. He graduated from the Eclectic Medical College of Cincinnati in 1896, and had specialized in otolaryngology. He was a member of the Vigo County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Lester Lymon Eberhart, M.D., of Angola, died suddenly on January 17, at the age of fifty-one. A graduate of Indiana University School of Medicine in 1930, Doctor Eberhart began the practice of surgery in 1931 at the Cameron Hospital in Angola, where he remained until 1944, when he severed his connection with the hospital to engage in private practice. In May, 1948, he founded and operated the Elmhurst Hospital in Angola, where he had served as chief surgeon since that time. He was a member of the Steuben County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

January 16, 1949

The Council of the Indiana State Medical Association convened for its midwinter meeting at 10:15 A.M., Sunday, January 16, 1949, in Private Dining Room No. 3 of the Columbia Club, at Indianapolis, with Dr. Alfred Ellison, chairman, presiding.

Roll call showed the following present:

Councilors:

First District	-----	Herman T. Combs, Evansville
Second District	-----	William C. Reed, Bloomington
Third District	-----	Not represented
Fourth District	-----	George A. May, Madison
Fifth District	-----	A. M. Mitchell, Terre Haute
Sixth District	-----	W. U. Kennedy, New Castle
Seventh District	-----	Not represented
Eighth District	-----	E. H. Clauser, Muncie
Ninth District	-----	Wemple Dodds, Crawfordsville
Tenth District	-----	W. H. Howard Hammond
Eleventh District	-----	Not represented
Twelfth District	-----	Paul A. Garber, South Whitley
Thirteenth District	-----	Alfred Ellison, South Bend

Officers:

Cleon A. Nafe, Indianapolis, president 1948.
 Augustus P. Hauss, New Albany, president 1949.
 Claude S. Black, Warren, president-elect.
 A. F. Weyerbacher, Indianapolis, treasurer.
 Frank B. Ramsey, Indianapolis, editor of *THE JOURNAL*.
 Albert Stump, Indianapolis, Attorney.
 Ray E. Smith, executive secretary.

Guests:

J. Neill Garber, Indianapolis, chairman, Committee on Centennial Arrangements.
 Thurman B. Rice, Indianapolis, chairman, Committee on Historical Exhibits.
 Don E. Wood, Indianapolis, co-chairman, Committee on Public Policy and Legislation.

On motion of Drs. Mitchell and Garber, the minutes of the Council meetings held on October 26 and 28, 1948, were approved as printed in the December, 1948, issue of *THE JOURNAL*.

Reports of Councilors

All councilors reported their district societies functioning well, with district meetings scheduled as follows:

3rd District—Corydon, May 25.
 6th District—New Castle, May 4.
 10th District—Whiting, March 16.
 11th District—Logansport, May 18.
 12th District—Fort Wayne, May 3 or 10.
 13th District—South Bend, November 9.

Reports of Officers

Dr. Cleon A. Nafe, president 1948. "I believe you have heard me talk enough in the past, and it should not be necessary for me to make any elaborate report as the retiring president. However,

I think I would be remiss in my duties if I did not convey to you a few very definite ideas that I have for your consideration.

"First, I have had the opinion for some time that the Council and the Board of Directors of the Mutual Medical Insurance Company should not be so nearly the same group. It was for that reason that I originally did not accept membership on that board. There should be a liaison by having some members of the Council on the board of directors, but that membership should be spread out, with other physicians more widely represented. There are two reasons for this: (1) by having to come to Indianapolis for so many meetings, the Councilors have made their responsibilities almost burdensome; (2) there are many physicians interested in this problem, and by widening their intimate knowledge of the Doctors' Plan, its activities could be more easily widened.

"The second belief I have is that our constitution and by-laws should be changed so that the retiring president should serve for one or two years as a councilor-at-large. I have felt in years past that it was unfortunate for the president to quit so abruptly at the time when he has the greatest amount of available information relative to the problems of the association, and that his services should be more gradually diminished. This would not affect me personally because it would take some time to make the change, and it is for that reason that I feel free to make the suggestion.

"The third idea I have is that this association should have a biennial House of Delegates meeting as the A.M.A. is now having. Our problems have become so complex that it is necessary that our state association become more closely tied to the county societies. More frequent meetings of the House of Delegates would accomplish that in a manner accomplished by the A.M.A.

"As I leave the responsibilities of this office I recognize that we have many problems. The A.M.A. House of Delegates asked each state association to sponsor a state law making the practice of giving or receiving rebates illegal. I personally believe this is a proper thing for the state association to do, and that more frequent meetings of our House of Delegates would enable the association to take more prompt action on this or other suggestions.

"As I have talked to medical groups over the state this year, I have made a plea that the medical profession must improve its public relations. Many unkind things have appeared in public print about the medical profession, much of which is untrue. But if we admitted that they were all true, it would still be my honest and humble opinion that, except possibly for the ministry, our profession throughout these United States

stands head and shoulders above all others in the contributions that have been made to the welfare of our people, and as a group I believe that the physicians of Indiana have probably done a better job than those in most other states in seeing that medical service is available at all times, in making reasonable charges for services, and being conscientious in their treatment of patients. While there is still need for the correction of some of our shortcomings, I think that we have a grand medical profession in the state of Indiana. Being convinced of this, I want to say, as I finish thirteen years as chairman of the Executive Committee and as president, that really, sincerely, honestly, it has been a great honor to have made my small contribution to this society."

Dr. Augustus P. Hauss, president. "Mr. Chairman, and members of the Council: I have no special report to make. I am very pleased with the progress that is being made by all agencies of our state medical association. The response to the appointments of committees was very gratifying and very surprising to me. At the present time there have been only three men who were unable to serve. Two of those definitely had very good reasons for not serving. The other man, it was not a major appointment by any means, just stated in his letter that he would not be able to accept the responsibility.

"I have had many conferences with various committee chairmen and I think within another month every committee will be functioning. I am asking every chairman and every committee to be active this year, and I am stating in the February President's Page that there must be no inactive or negative reports filed by any committee in the archives of the centennial year.

"I am very gratified with the way things are going and I believe we are going to have an excellent year."

Dr. A. F. Weyerbacher, treasurer, presented the following report which was compiled by George S. Olive and Company, certified public accountants:

Treasurer's Report

January 10, 1949.

The Council,
Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association for the year ended December 31, 1948, for the purpose of verifying the assets, liabilities, and fund balances at December 31, 1948, and of reviewing the income and expense accounts for the year then ended on a cash receipts and disbursements basis. In connection, therewith, we have reviewed the system of internal control and the accounting procedures of the Association, and have examined and tested accounting records and

other supporting evidence, by methods and to the extent we deemed appropriate.

In our opinion, subject to the comments made herein, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1948, and the results of operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

GENERAL COMMENT

In exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1948, showing in summary form the sources from which this increase was derived.

The increase of \$13,073.88 resulted from an excess of operating cash receipts over operating cash disbursements in the general fund. Increases in the general fund are due mainly to additional income from exhibits and additional income from membership dues. Additional United States Savings Bonds in the amount of \$10,000 were purchased for the general fund. A complete analysis of the increases and decreases in the general fund is presented in exhibit C.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1948, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, which are kept in the Association's safe deposit box in the Indiana National Bank. Cash on deposit in banks was confirmed by direct correspondence with the depositories.

Analyses of the cash receipts and disbursements of the general fund, of THE JOURNAL of the Indiana State Medical Association, and of the Medical Defense Fund are presented in exhibits C, D, and E.

Yours very truly,

Geo. S. Olive & Co.,

Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION Analysis of Increase in Assets, All Funds, Year Ended December 31, 1948

TOTAL ASSETS, DECEMBER 31, 1948—

Exhibit B -----	\$80,646.23
TOTAL ASSETS, DECEMBER 31, 1947-----	67,572.35
NET INCREASE -----	\$13,073.88

Arising from the following sources:

Excess of operating cash receipts over operating cash disbursements, general fund, year ended December 31, 1948	
Receipts—	
Exhibit C -----	\$68,754.38
Disbursements—	
Exhibit C -----	64,137.74
	<hr/>
	\$4,616.64

U. S. Government bonds purchased -----	10,000.00	
		\$14,616.64
Excess of operating cash disbursements over oper- ating cash receipts, The Journal of the Indiana State Medical Association, year ended December 31, 1948:		
Receipts—		
Exhibit D -----	\$40,380.05	
Disbursements—		
Exhibit D -----	41,453.06	
		(1,073.01)
Excess of operating cash disbursements over oper- ating cash receipts, Medi- cal Defense Fund, year ended December 31, 1948:		
Receipts—		
Exhibit E -----	\$2,980.25	
Disbursements—		
Exhibit E -----	3,450.00	
		(469.75)
TOTAL NET INCREASE -----		\$13,073.88
		Exhibit B
INDIANA STATE MEDICAL ASSOCIATION		
Statement of Assets, All Funds,		
at December 31, 1948		
GENERAL FUND:		
Cash on deposit—Exhibit C-----	\$16,195.94	
Petty cash fund-----	200.00	
Investments:		
Marion County Flood		
Prevention bonds--\$3,000.00		
Indianapolis City		
Hospital bonds--- 5,000.00		
U. S. Treasury bonds 8,000.00		
U. S. Savings bonds--25,000.00		
	41,000.00	
Total general fund -----		\$57,395.94
THE JOURNAL OF THE INDI- ANA STATE MEDICAL ASSO- CIATION:		
Cash on deposit—Exhibit D-----		5,799.57
MEDICAL DEFENSE FUND:		
Cash on deposit—Exhibit E-----	2,450.72	
Investments:		
Marion County Flood		
Prevention bonds_ 2,000.00		
U. S. Treasury bonds 5,000.00		
U. S. Savings bonds_ 5,000.00		
U. S. Baby bonds--- 3,000.00		
	15,000.00	
Total Medical Defense fund -----		17,450.72
TOTAL ASSETS, ALL FUNDS—		
Exhibit A		\$80,646.23
		Exhibit C
INDIANA STATE MEDICAL ASSOCIATION		
Comparative Statement of Cash Receipts		
and Disbursements,		
Years Ended December 31, 1948,		
and December 31, 1947		
	Year Ended	
	Dec. 31	Dec. 31, Increase
	1948	1947 (Decreased)
CASH BALANCE AT		
BEGINNING OF		
YEAR -----	\$11,579.30	\$ 5,613.25 \$ 5,966.05

RECEIPTS:			
Membership dues -----	52,039.00	50,115.00	1,924.00
Income from exhibits_	12,676.23	6,886.25	5,789.98
Interest income:			
U. S. Treasury bonds	212.50	212.50	-----
U. S. Savings bonds	437.50	250.00	187.50
Indianapolis, Indi- ana, City Hospi- tal bonds -----	200.00	200.00	-----
Marion County, In- diana, Flood Pre- vention bonds ----	127.50	127.50	-----
Meyer Nurse Scholar- ship fund -----		600.00	(600.00)
Krannert Nurse Schol- arship fund -----	800.00	400.00	400.00
Egbert Medical Schol- arship fund -----	200.00	-----	200.00
Centennial book fund_	930.80	-----	930.80
Refunds on annual session -----	875.94	306.25	569.69
Instructional courses_	197.83	-----	197.83
Other refunds -----	57.08	-----	57.08
Check written off-----		7.50	(7.50)
	68,754.38	59,105.00	9,649.38

BEGINNING BAL- ANCE PLUS CASH RECEIPTS -----	80,333.68	64,718.25	15,615.43
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DISBURSEMENTS:			
Transfer of applicable portion of dues to The Journal of The Indiana State Medi- cal Association—Ex- hibit D -----	10,970.00	7,198.00	3,772.00
Medical Defense fund —Exhibit E-----	2,630.25	2,586.75	43.50
Purchase of securities	10,000.00	5,000.00	5,000.00
Headquarters office ex- pense -----	16,792.58	14,563.37	2,229.21
Publicity committee---	1,361.00	771.59	589.41
Public policy -----	1,483.26	2,513.67	(1,030.41)
Council -----	1,750.79	6,392.10	(4,641.31)
Officers -----	639.33	915.78	(276.45)
Annual session -----	8,743.22	6,834.76	1,908.46
Miscellaneous commit- tees -----	7,386.90	4,312.17	3,074.73
Federal old age bene- fits tax -----	81.88	76.88	5.00
Postgraduate study---	456.04	191.77	264.27
Refunds of dues-----	12.00	-----	12.00
National conference on Medical Service -----		7.63	(7.63)
Refunds on exhibit rent -----	181.25	31.25	118.75
Fifty-Year Club-----	234.67	1,143.23	(908.56)
Women's Auxiliary of I. S. M. A. -----	800.00	600.00	200.00
General practitioner award -----	61.01	-----	61.01
Instructional courses_	2.00	-----	2.00
Field secretary -----	551.56	-----	551.56
	64,137.74	53,138.95	10,998.79

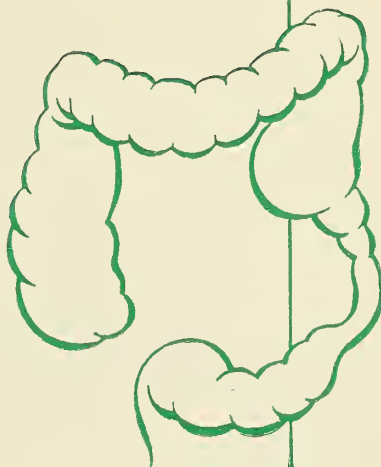
CASH BALANCE AT END OF YEAR	\$16,195.94	\$11,579.30	\$ 4,616.64
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Exhibit D

INDIANA STATE MEDICAL ASSOCIATION	
Statement of Cash Receipts and Disbursements,	
Year Ended December 31, 1948	
The Journal of the Indiana State Medical Association	
BALANCE, JANUARY 1, 1948-----	\$ 6,872.58
RECEIPTS:	
Subscriptions — members—Ex- hibit C -----	\$10,970.00

Bowel Management of the Irritable Colon . . .

"As an aid in reestablishing a normal rhythm, the temporary use of a bland bulk-producer . . . may be beneficial. . . Patients having irritable colon who believe they are suffering from constipation commonly use high-residue diets, . . . They may not realize that this practice is similar to using irritating cathartics or large enemas and often increases the tendency to constipation by increasing spasm of the colon."*



Metamucil is "a bland bulk-producer" which gently initiates reflex peristalsis and movement of the intestinal contents. The "smoothage" therapy of Metamucil encourages a return of the normal function of the colon without irritating the mucosa.

METAMUCIL®

is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.



SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Collins, E. N.: The Diagnosis and Treatment of Irritable Colon: Physiologic, Local, Irritative and Psychosomatic Factors, *M. Clin. North America* 32:398 (March) 1948.

Subscriptions—non-members	449.50
Advertising	28,497.76
Collections on accounts receivable	90.00
Single copy sales	222.50
Electrotypes	150.29
Total receipts—Exhibit A	40,380.05
	47,252.63

DISBURSEMENTS:

Salaries	10,956.87
Printing	26,391.00
Office postage	353.30
Journal postage	525.97
Advertising commissions	229.50
Electrotypes	644.09
Refurbishing	439.39
Press clippings	129.64
Editor and editorial board expense	88.93
Office supplies	788.09
Rent	480.00
Electricity	25.93
Telephone and telegraph	219.25
Federal old age benefits tax	68.47
Miscellaneous	112.63

Total disbursements—Exhibit A	41,453.06
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BALANCE, DECEMBER 31, 1948

Exhibit B	\$ 5,799.57
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Exhibit B**INDIANA STATE MEDICAL ASSOCIATION**

**Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1948
Medical Defense Fund**

BALANCE, JANUARY 1, 1948	\$2,920.47
--------------------------	------------

RECEIPTS:

Transfer of applicable portion of dues from the general fund—Exhibit C	\$2,630.25
Interest income:	
U. S. Treasury bonds	140.00
U. S. Savings Bonds	125.00
Marion County Flood Prevention bonds	85.00

Total receipts—Exhibit A	2,980.25
	5,900.72

DISBURSEMENTS:

Malpractice fees	1,650.00
Attorney fees	1,800.00

Total disbursements—Exhibit A	3,450.00
-------------------------------	----------

BALANCE, DECEMBER 31, 1948

—Exhibit B	\$2,450.72
------------	------------

DR. FRANK B. RAMSEY, editor of THE JOURNAL, announced that a meeting of the Editorial Board would be held on January 23, at which time JOURNAL policies would be discussed. "My policy for THE JOURNAL will be to spread the work out as much as possible, not only on the scientific content of THE JOURNAL but also in the inclusion of all organization items and news items. Printing costs increased by 13 percent the first of this year, which puts it up to us to run THE JOURNAL as economically as possible. We, of course, will in-

crease our advertising rates January 1. From a practical standpoint we don't know what effect that will have. We hope advertising revenue will increase.

"We shall try to keep the doctors informed as much as possible on all questions of an economic nature, including socialized medicine. That leaves us with a job of curtailing the scientific articles. One thing in that regard: at the state meeting I discussed with some of the essayists their willingness not to have their papers published. Some of them are actually interested in not having their papers published. The coming year the scientific content of THE JOURNAL, I feel, will be less than it has been in years before."

Unfinished Business

1. *Committee on Medical and Nursing School Scholarships.* The executive secretary reported that there had been no change in the scholarship roster of the association, which includes eleven student nurses, four of whom are sponsored by the Krannert fund and one by the Meyer fund, and six directly by the association, and six medical students, all of whom are sponsored by the association.

2. *Progress of Mutual Medical Insurance, Inc.* Dr. Kennedy, president, reported that "the company as an organization is doing very satisfactorily. However, we have fallen down in not selling enough people in it. The reason for the formation of the company was to insure people so that they would feel that they are getting medical care and would not be asking the government to supply it. In that respect it has fallen down. We need to put more people out to sell our policy. We should have a half million enrolled."

Following discussion by Drs. Howard, Dodds, Kennedy, Weyerbacher and Mr. Stump, on motion of Drs. Howard and Garber the Council went on record as approving the widening of the efforts of the Blue Shield and the extension of its promotional organization and activities, especially with reference to the acceleration of its rate of enrollment.

3. *Allen County requests for funds to finance postgraduate courses.* Dr. Clauser, chairman of the Committee on Medical Education and Hospitals, reported that this request had been presented to the House of Delegates in the form of a resolution and the resolution had been referred to the Committee on Medical Education and Hospitals. Dr. Clauser said, "So far as the committee members are concerned, they feel that until the Council and the state medical association as a whole set up a policy, which perhaps would be worked out in detail by the Committee on Medical Education and Hospitals, providing statewide approval of postgraduate programs, it is not good judgment to allocate funds to any county medical society until plans of its program are submitted. My committee has no recommendation to make except in a negative way; we feel that we have no

"CHANGE TO PHILIP MORRIS

OR...

CUT DOWN YOUR SMOKING!"

**That is the suggestion of many of the country's
leading specialists in cases of throat irritation.***

Many doctors have among their patients some who they believe smoke too much. But the difficulty of persuading such smokers to cut down is familiar to everyone. What better advice therefore than "Change to Philip Morris"...the only leading cigarette proved definitely and measurably less irritating.

To minimize cigarette irritants, Philip Morris are made by a special process whose advantages are conclusively shown in published studies.** These studies may convince you too that the most effective advice for patients who smoke is "Change to Philip Morris."



PHILIP MORRIS

Philip Morris & Co., Ltd., Inc.
119 Fifth Avenue, New York

ARE YOU A PIPE SMOKER? . . . We suggest an unusually fine new blend — **COUNTRY DOCTOR PIPE MIXTURE.** Made by the same process as used in the manufacture of Philip Morris Cigarettes.

**Completely documented evidence on file.*

***Reprints on request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

authority to advise setting funds aside for this purpose until a statewide policy has been established."

Dr. Garber explained that the Allen county resolution came from one of the delegates from that county as an individual matter and not as a request from the Allen County Medical Society. In view of this fact, a motion by Drs. Garber and Howard that this matter be dropped was adopted by the Council.

Suggestions and Proposals for 1949 (Centennial) Annual Session at Indianapolis

1. *Dates set by Executive Committee*—Monday, Tuesday, Wednesday and Thursday, September 26, 27, 28 and 29, 1949.

2. *Convention headquarters*—Murat Temple.

3. *Report of Committee on Centennial Arrangements*. Dr. J. Neill Garber, chairman, presented the following proposed plans of his committee for the centennial session:

(1) Scientific papers on subjects of practical interest.

(2) Instructional courses.

(3) Audio-visual program, which will have one innovation—movies on scientific subjects, and television in the convention hall, with the program originating at the medical center. The television probably will alternate with the movie presentation during three days.

(4) Three types of exhibits: scientific, historical, and technical. Request has been made for 40 to 50 scientific exhibits. A great deal of emphasis will be placed on the historical exhibits.

(5) *Evening programs:*

Monday evening.

a. Stag and smoker for the members only, with dinner, and entertainment throughout the entire evening. Each man is to be assessed \$2.00 for the stag dinner.

b. Dinner for women physicians.

c. Dinner and/or other entertainment for wives and women guests of physicians.

Tuesday evening. Public meeting with speaker of national renown, and musical entertainment. It is planned either to arrange for a large auditorium and to invite the public, or to have radio time and a closed meeting. This will be the biggest evening program of the whole week.

Wednesday evening. Meeting, with a scientific speaker on medicine or a related subject, for members, their wives and guests.

No dinner plans will be made for Tuesday or Wednesday evenings in order to allow ample time for fraternity, class, servicemen's and individual dinners and get-togethers.

Thursday evening. Banquet, with one of the most outstanding dinner speakers in the country, music and entertainment during the dinner, followed by a dance.

(6) *Budget.* On motion of Drs. Mitchell, May and Garber, the Council authorized an expenditure up to \$10,000.00 on entertainment for the centennial celebration.

(7) All hotel reservations will be handled through a central housing committee under the direction of Dr. J. E. Gillespie.

(8) The Committee on Centennial Arrangements has taken no action on the matter of publicity for the centennial session.

(9) The committee is composed not only of the members listed by name but includes also the presidents of the district medical societies. It is hoped that these men out in the districts will arouse the interest of their members in the centennial celebration and exert every effort to make this the largest and best attended state meeting ever held.

4. *Report of Committee on Historical Exhibits.* Dr. Thurman B. Rice, chairman, outlined in detail the plans of his committee for the centennial historical exhibit, which will be an important feature of the annual session.

It was taken by consent, in reply to Dr. Rice's question, that the public should be invited to view the historical exhibits.

On motion of Drs. Black and Kennedy, the Council voted to allow the Committee on Historical Exhibits a budget of \$1,250.00 with which to create this exhibit, with full power to spend this amount the way it sees fit.

5. *Type of scientific meetings.* The executive secretary read the following resolutions which were passed by the Section on Ophthalmology and Otolaryngology at its meeting on October 27, 1948:

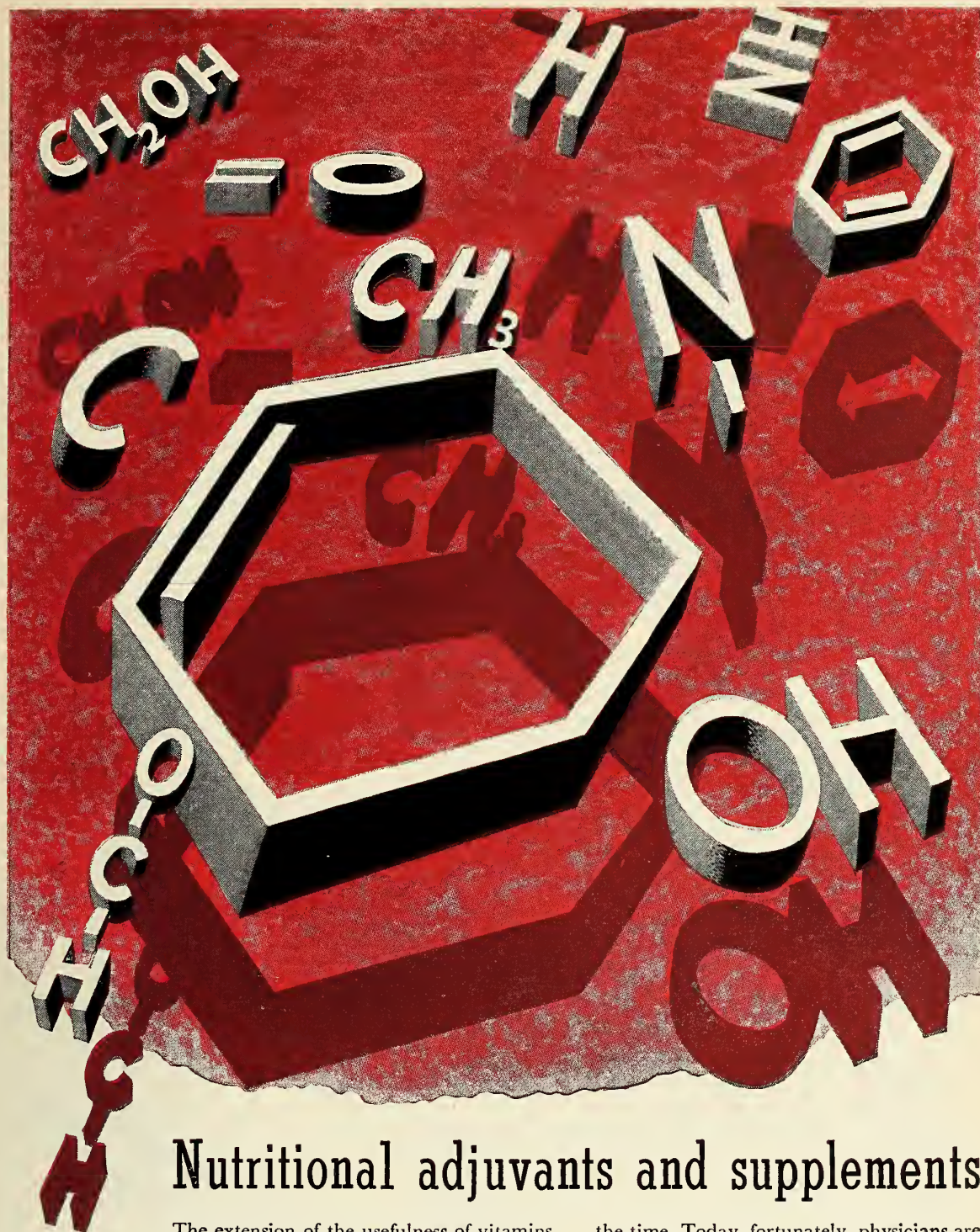
(1) BE IT RESOLVED That the EENT Section of the Indiana State Medical Association notify the Council of the Association that the abolishment of sectional meetings has deprived the members of the EENT Section of much of the value and inspiration of the State Medical Meeting of 1948.

We respectfully recommend to the Council that the EENT sectional meetings be reinstated in the future programs of the Indiana State Medical Association.

(2) Dr. Dillon Geiger moved to recommend that the general program include a paper by both an Eye and ENT speaker.

On motion of Drs. Mitchell, Garber and Combs, the Council approved the continuance of general scientific meetings, and suggested that noon luncheons with panel discussions be held by the various sections if they want them.

6. *Report of Committee on Centennial History and Publications.* The executive secretary reported on the present status of the book to be published commemorating one hundred years of Indiana medicine. Dr. Hauss suggested that the inclusion of a complete membership roster would triple the sale of this book. He asked each councilor to assume the duty of addressing a letter to each sec-



Nutritional adjuvants and supplements

The extension of the usefulness of vitamins, beyond the specific deficiencies which they cure and prevent, is a therapeutic phenomenon of the past decade. Those who specialize in nutritional disease have frequently emphasized to physicians the doctrine that every cell in the body needs every vitamin all of

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retary in his district to stimulate the sale of this book.

Following discussion, on motion of Drs. Combs and Mitchell, the Council approved the publication of a notice in the February JOURNAL stating that the prepublication price is \$2.20 and that the post-publication price will be \$4.00. April first was set as the deadline for prepublication orders.

It was taken by consent that decision on the number of books to be printed be postponed until the April meeting of the Council.

It was announced that the book would be published for delivery in September.

Membership Problems

1. *Dues of physicians in military service.* On motion of Drs. Clauser and Combs, the Council voted to continue the policy of allowing physicians in active military service to become members of the association without the payment of membership dues.

2. *Membership in Fifty-Year Club.* On motion of Drs. Garber and Mitchell, the Council voted that a physician who has never belonged to his county medical society shall not be recognized as a member of this club.

3. *Suggestions for county society programs.* The Council adopted the motion made by Drs. Howard and Kennedy that the executive secretary contact the secretaries of the county medical societies, suggesting that each of the societies hold a meeting, either in February or March, devoted entirely to the discussion of socialized medicine. Mr. Stump suggested that it would be well to invite lay groups in to hear the discussion.

4. Membership report.

MEMBERSHIP REPORT

Indiana State Medical Association
December 31, 1948

County Society	No. of M.D.'s in County*	Members Dec. 31, 1948	Members Dec. 31, 1947	Out-of-State Members
1st District				
Posey	13	13	13	2
*Vanderburgh	204	178	166	4
Warrick	15	11	12	
Spencer	11	9	9	1
Perry	12	11	10	
Gibson	27	29	27	
Pike	9	9	8	1
Total	291	260	245	8
2nd District				
*Knox	50	37	46	1
Daviess-Martin	28	24	24	1
Sullivan	23	19	19	1
Greene	21	20	18	
Owen-Monroe	49	46	44	
Total	171	146	151	3
3rd District				
Lawrence	29	28	24	2
*Orange	15	15	13	
Crawford	4	4	5	
*Washington	9	10	10	1
Scott	6	4	5	
Clark	25	21	25	1
*Floyd	36	34	37	
Harrison	11	11	8	
Dubois	19	18	18	
Total	154	145	145	4
4th District				
*Bartholomew-Brown	36	30	32	1
Decatur	18	15	16	
Jackson	20	18	18	
*Jennings	9	9	8	
Ripley	15	12	12	
Jefferson	27	22	22	2
Switzerland	5	5	6	
*Dearborn-Ohio	18	18	16	
Total	148	129	130	3
5th District				
Parke-Vermillion	31	27	27	
Putnam	21	19	18	
Vigo	129	121	110	3
Clay	14	13	14	
Total	195	180	169	3
6th District				
Hancock	19	20	21	
*Henry	37	36	36	1
Wayne-Union	75	67	65	3
Rush	14	13	15	
Fayette-Franklin	27	21	20	1
Shelby	29	25	25	1
Total	201	182	182	6
7th District				
*Hendricks	20	18	18	1
Marion	919	845	868	45
*Morgan	26	22	17	
*Johnson	20	19	19	
Total	975	904	922	46
8th District				
*Madison	96	86	82	
*Delaware-Blackford	114	104	99	5
Jay	23	20	19	
*Randolph	30	26	26	
Total	263	236	226	5
9th District				
Benton	10	10	11	
*Fountain-Warren	18	18	17	
*Tippecanoe	100	97	95	2
*Montgomery	36	32	31	
Clinton	31	29	28	
Tipton	15	12	12	
Boone	25	20	21	
Hamilton	28	24	22	
White	9	4	3	
Total	272	246	240	2
10th District				
*Lake	310	295	277	11
*Porter	31	27	25	3
*Jasper-Newton	21	21	21	3
Total	362	343	323	17
11th District				
Carroll	11	10	10	
*Cass	42	35	34	1
*Miami	24	21	20	
*Wabash	26	23	24	1
*Huntington	25	24	24	

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County Society	No. of M.D.'s in County ^a	Members Dec. 31, 1948	Members Dec. 31, 1947	Out-of-State Members
11th District (Cont.)				
Howard	42	38	36	1
*Grant	58	53	56	1
Total	228	204	204	4
12th District				
LaGrange	7	5	5	
Steuben	16	12	11	
*Noble	28	27	26	1
DeKalb	21	21	23	1
*Whitley	17	12	10	
*Allen	207	199	194	12
Wells	24	22	25	2
*Adams	22	17	18	
Total	342	315	312	16
13th District				
*LaPorte	68	62	60	
St. Joseph	197	183	166	7
*Elkhart	86	81	78	1
Starke	6	6	5	
Pulaski	8	8	8	
Fulton	14	12	14	
*Marshall	27	25	22	1
Kosciusko	21	18	16	2
Total	427	395	369	11

SUMMARY BY DISTRICTS

1st District	291	260	245	8
2nd District	171	146	151	3
3rd District	154	145	145	4
4th District	148	129	130	3
5th District	195	180	169	3
6th District	201	182	182	6
7th District	975	904	922	46
8th District	263	236	226	5
9th District	272	246	240	2
10th District	362	343	323	17
11th District	228	204	204	4
12th District	342	315	312	16
13th District	427	395	369	11
Total	4,029	3,685	3,618	128

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

^a 55 physicians received membership gratis in 1948 because of military service.

179 physicians were honorary members in 1948.

Legislative Matters

1. Dr. Don E. Wood, co-chairman of the Committee on Public Policy and Legislation, spoke briefly on the duties and work of his committee. "A more active interest on the part of doctors in legislation, both state and national, is one solution to a lot of our problems," he said.

2. The executive secretary reported that following election he had made an effort to contact all the senators and congressmen and he had been successful in arranging interviews with seven of them.

3. *Socialized medicine.* Dr. Howard spoke of the importance of the councilors taking the initiative in arranging meetings in their districts to be held during January and February with business and labor groups to discuss socialized medicine. Dr.

Mitchell said the doctors in his society who belong to service clubs are arranging programs for their various clubs on medical subjects.

New Business

1. *Public relations.* Dr. Dodds, chairman of the Committee on Public Relations, reported on a meeting of his committee and the activities planned by the committee for 1949.

2. *Indiana Inter-Professional Health Council.* On motion of Drs. Mitchell and Howard, Dr. E. H. Clauser was reappointed and Dr. William C. Reed was elected to serve as members of the Committee on Indiana Inter-Professional Health Council for 1949.

3. *Increase in amount taken from each member's dues for medical defense fund.* The executive secretary read the following paragraph from the minutes of the October 25, 1948, meeting of the Executive Committee:

"The treasurer made a report on the medical defense fund receipts and expenditures for the past ten years and recommended that the By-laws be amended to take \$1.50 from each member's dues instead of \$.75 for deposit in this fund. Motion was made by Drs. Nafe and Porteus that the report be referred to the Council with the recommendation that the Council recommend that the By-laws be changed to set aside \$1.25 from each membership for the medical defense fund."

On motion of Drs. Garber and May, the Council voted to recommend to the House of Delegates that the By-laws be changed so that \$1.25 shall be taken from each member's dues for deposit in the medical defense fund.

4. *Election of alternate delegates to A.M.A. to replace Dr. Norman Beatty, deceased.* On motion of Drs. Dodds and Garber, Dr. Cleon A. Nafe, Indianapolis, was elected alternate delegate to the American Medical Association to fill Dr. Beatty's unexpired term, ending December 31, 1949.

5. *Nominations for Editorial Board.* Dr. Black nominated Dr. Wemple Dodds, Crawfordsville (roentgenology). Dr. Combs nominated Dr. Stephen L. Johnson, Evansville (internal medicine).

Additional nominations may be made at the next Council meeting.

6. *Matters referred to Council by Executive Committee.*

(1) *Scholarship medals for medical school graduates.* In accordance with the action taken a year ago by the Council, gold, silver and bronze medals were presented to the three men with the highest scholastic standing in the senior medical class. As no acknowledgment was received from any one of the students so recognized, on motion of Drs. Mitchell and Garber the Council decided to discontinue the practice of awarding these medals.

(2) *Proposed amendment to law governing qualifications of heads of state mental institutions.* The possibility that a bill to amend the present law which requires the heads of state mental institutions to be physicians and to have had two years'



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experience in institutional work to permit the Governor to appoint laymen to fill these positions was referred to the Council for a definite expression in case such a bill is introduced at this session of the legislature. Following discussion by Drs. Ellison, Mitchell, Dodds, Combs, Kennedy and May, on motion of Drs. Mitchell and Kennedy the Council approved the recommendation that the heads of the state mental institutions shall be physicians and that they shall be empowered to employ business managers to handle the administrative work of the institution, and that the present requirement that these heads shall have had two years' experience in institutional work be eliminated from the law.

7. *Spring meeting of the Council.* It was taken by consent that the next meeting of the Council should be held on Sunday, April 10, 1949.

Elections for 1949

1. *Executive Committee members.* On motion of Drs. Black and Combs, Dr. C. H. McCaskey and Dr. Walter L. Portteus were re-elected members of the Executive Committee for 1949.

2. *Chairman of Council.* On motion of Drs. Black and Reed, Dr. Alfred Ellison was re-elected chairman of the Council for 1949.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

January 15, 1949.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: Cleon A. Nafe, M.D., and J. Neill Garber, M.D.

Membership Report

Number of members December 31, 1948. 3,683*

Number of members December 31, 1947. 3,618

Gain in 1948. 65

* Includes 55 in military service (gratis)

179 honorary members

Treasurer's Office

Auditor's report for year ending December 31, 1948, was read.

On motion of Drs. Ellison and Hauss it was voted to bond the treasurer, executive secretary and assistant executive secretary.

Statements of receipts and expenditures for December for the association and THE JOURNAL were approved.

1949 Annual Session Indianapolis,
September 26-29, 1949

Meeting facilities. After the executive secretary had read a letter from the building manager

of the Murat Temple quoting rental fees for the 1949 meeting, the president and executive secretary were authorized to see if the Murat Temple would reduce its quotation and to investigate the availability of other facilities in Indianapolis.

Banquet speaker. On motion of Drs. Hauss and Ellison, the committee accepted the recommendation of the Committee on Centennial Arrangements that Mr. Kenneth McFarland, superintendent of schools of Topeka, Kansas, be speaker at the banquet.

Request for exhibit space. On motion of Drs. Hauss and Ellison, the committee approved extending an invitation to the F. E. Young and Company, Chicago, to exhibit at the 1949 meeting.

Entertainment. The chairman of the Committee on Centennial Arrangements reported on the entertainment features for the meeting. (See page 266.)

Legislative Matters

National

The executive secretary reported on his contacts with Indiana senators and congressmen regarding compulsory sickness insurance.

The Executive Committee voted to renew the subscription for five persons to the Shearon Medical Service at a total cost of \$75.00 for the year. This was done on motion of Drs. Ellison and Black.

The chairman of the committee and the attorney reported on meetings which had been held to form an organization to educate the public upon the evils of government control of medicine.

Local

The executive secretary reported that a bill is to be introduced in the Senate requiring persons who practice psychiatry to have unlimited licenses to practice medicine.

The question of the state association's position upon a bill which would permit the appointment of a layman as superintendent of a state hospital, with a physician heading the medical service and not under the lay superintendent, was referred to the Council.

Action of A.M.A. Committee on Rebates. The action of a special A.M.A. Committee on Rebates was referred to the Indiana State Medical Association House of Delegates, on motion of Drs. Black and Hauss.

Organization Matters

A.M.A. broadcast, "Your Health Today." The chairman of the Committee on School Health and Physical Education was selected to speak on the A.M.A. broadcast, "Your Health Today," on February 26, 1949, upon motion of Drs. Hauss and Ellison.

The executive secretary announced his election as a director of the Indiana State Conference on Social Work.

What is an equitable fee for performing an appendectomy? Letter from the secretary of the

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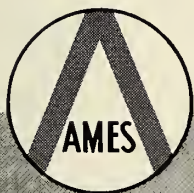
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Daviess-Martin County Medical Society reporting that the United Mine Workers had refused to pay one of its surgeons \$150.00 for an appendectomy but offered to pay \$100.00, which is the fee allowed in the Veterans Administration fee schedule, brought to the attention of the committee. After some discussion the executive secretary was directed to write the Daviess-Martin County Medical Society to try to settle the controversy without its getting into court.

The president of the state association announced his intention to appoint a committee to draft a fee schedule which will be agreeable to the United Mine Workers of America and the state medical association.

Headquarters office telephone service. On motion of Drs. Ellison and Black, the headquarters office was authorized to place THE JOURNAL office on an extension and add a new line to the headquarters office.

On motion of Drs. Black and Hauss, the executive secretary was given permission to buy what he thinks is a suitable new typewriter for the office.

Woman's Auxiliary

The committee approved any one of the four speakers being considered for the annual House of Delegates' meeting of the Woman's Auxiliary at Huntington on April 26 and 27, 1949.

The committee voted \$800.00 to the Woman's Auxiliary for its 1949 budget, with the provision that any surplus be returned to the association, on the motion of Drs. Hauss and Black.

Annuity Policy for Executive Secretary

The committee voted to recommend to the Council that a fifteen-year annuity insurance policy in the amount of \$10,000, at an annual premium of \$816.00, be purchased upon the life of, and for, the executive secretary in the name of the association.

THE JOURNAL

Report on advertising:

Increase to date for 1949 ----- \$462.00

There being no further business, the committee adjourned to meet again at 10:00 a.m., Sunday, February 20, 1949, at the Columbia Club.

COMMITTEE ON PUBLICITY

January 7, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D., and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of February 14, 1949—"Increased Years."

Week of February 21, 1949—"Walk, Don't Run."

Week of February 28, 1949—"Nervous Stomach."

The committee decided to ask *The Kokomo Tribune* for permission to circulate an editorial entitled "Dangers in State Medicine," appearing in its December 30, 1948, issue, in condensed form.

A "Letter to the Editor" in reply to an article about displaced doctors being barred from practice in Indiana

by the State Board of Medical Registration and Examination in *The Indianapolis Star* of January 5, 1949, was approved.

A radio series on physical medicine was selected to follow "Dodging Contagious Diseases," which ends February 5, 1949, on WFBM, Indianapolis.

Dr. Walter L. Portteus, a member of the Executive Committee, appeared before the committee to urge all-out action against the Truman-Ewing compulsory sickness tax.

Budget request of the committee for 1949 was set at \$7,000, \$5,000 of which would be for mileage and honorariums for speakers against compulsory sickness insurance.

Speakers procured:

January 11, 1949—Kiwanis Club, Frankfort. "Socialized Medicine," field secretary.

February 2, 1949—Woman's Auxiliary, Marshall County Medical Society, Plymouth. "Compulsory Sickness Insurance," executive secretary.

January 21, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Larry Richardson, field secretary, and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of March 7, 1949—"That Let Down Feeling."

Week of March 14, 1949—"Recipe for Long Life."

A letter from the editor of *The Kokomo Tribune* was read in which he explained that the editorial, "Dangers in State Medicine," could be used in its entirety with credit, or without credit if condensed. The committee deferred action.

The executive secretary presented an article against compulsory sickness insurance which was written by request of the Elkhart County Medical Society for publication in *The Elkhart Truth*.

The chairman announced that the Budget Committee had appropriated \$3,500.00 to the committee for its 1949 activities.

Speakers procured:

January 25, 1949—Veterans of Foreign Wars, Tyndall Towne, Indianapolis. "Chiropractic Legislation," executive secretary.

January 28, 1949—Woman's Club, Delphi. "Compulsory Sickness Insurance," chairman of Legislative Committee, State Woman's Auxiliary.

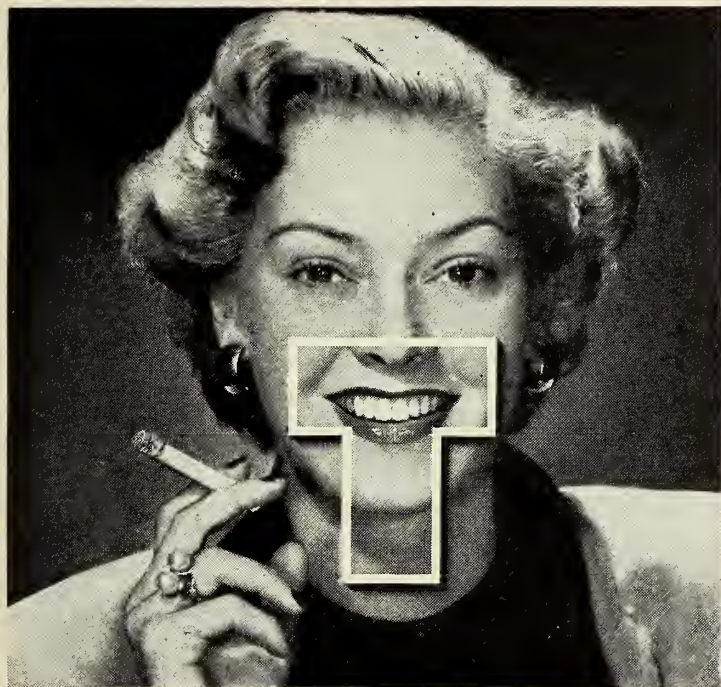
The executive secretary was instructed to fill all requests for speakers on the subject of government control of medicine even if necessary to pay mileage and an honorarium.

LOCAL SOCIETY REPORTS

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President, O. L. Wood, Brazil,
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Vice-President, L. L. Nesbit, Anderson,
Secretary-Treasurer, J. L. Lamey, Anderson.

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President, William E. Schofield, Orleans,
Vice-President, N. E. Keseric, French Lick,
Secretary-Treasurer, Keith Hammond, Paoli.

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President, Hardin S. Dome, Tell City,
Vice-President, Earl R. Snyder, Troy,
Secretary-Treasurer, David A. Dukes, Tell City.

POSEY COUNTY MEDICAL SOCIETY

President, Paul Boren, Poseyville,
Vice-President, A. L. Woods, Poseyville,
Secretary-Treasurer, L. John Vogel, Mount Vernon.

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President, Lloyd Hisrich, Batesville,
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Vice-President, D. W. Frash, South Bend,
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Vice-President, Boyd A. Burkhardt, Tipton,
Secretary-Treasurer, George Compton, Tipton.

WABASH COUNTY MEDICAL SOCIETY

President, J. F. Mills, Wabash,
Vice-President, J. G. Kidd, Roann,
Secretary-Treasurer, F. M. Whistler, Wabash.

WASHINGTON COUNTY MEDICAL SOCIETY

President, Kermit Tower, Campbellsburg,
Vice-President, John I. Mitchell, Salem,
Secretary-Treasurer, J. P. Gilliatt, Salem.

WELLS COUNTY MEDICAL SOCIETY

President, Allen C. Nickel, Bluffton,
Vice-President, Thomas O. Dorrance, Bluffton,
Secretary-Treasurer, Homer B. Annis, Bluffton.

LOCAL SOCIETY REPORTS

Adams County Medical Society members met at the Adams County Memorial Hospital, in Decatur, on January 11. This was a business meeting, and ten members were present.

* * *

DeKalb County Medical Society members held a meeting at the Auburn Hotel, in Auburn, on January 12. Fifteen members were present for the business meeting and election of officers.

* * *

Fayette-Franklin County Medical Society members held a meeting on January 11 at the Connersville Country Club. The guest speaker was Dr. Irving Rosenbaum, of Indianapolis, whose subject was "Acute Rheumatic Fever." Sixteen members were present.

* * *

Gibson County Medical Society members held a meeting on January 10 at the Hotel Emerson, in Princeton. The twenty members present heard Dr. Nathaniel Ewing, of Vincennes, discuss "Recent Advances in Diagnosis and Treatment of Common Malignant Lesions."

* * *

Greene County Medical Society members met at the Freeman Greene County Hospital in Linton on January 13. This was a business meeting, and fifteen members were in attendance.

* * *

Hamilton County Medical Society members met at the Firestone Cafeteria in Noblesville on January 11. This was a joint meeting with the Hamilton County Tuberculosis Association. Eight members of that organization were present, as well as ten members of the county medical society. The guest speaker was Dr. James H. Stygall, of Indianapolis, who presented x-rays of clinical cases of tuberculosis.

* * *

Hendricks County Medical Society members met at Canterbury College, in Danville, on January 26. The guest speakers were Mr. Albert Stump, of Indianapolis, attorney for the state association, and Mr. R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc., who participated in a panel discussion on "Voluntary Health Insurance vs. the Proposed Compulsory Governmental Plan." Seven members were present.

* * *

Henry County Medical Society members met at the Henry County Hospital, in New Castle, on January 20. The twenty members present heard Mr. Edward Morris and Mr. R. S. Saylor, of Mutual Medical Insurance, Inc., discuss voluntary hospitalization programs on a community-wide basis.

* * *

Howard County Medical Society members held a meeting in Kokomo, on January 7, when twenty-eight members and five guests were present. Drs. T. B. Bauer and H. M. Trusler, of Indianapolis, talked on "Plastic Surgery About the Face."

* * *

Knox County Medical Society members met in Vincennes on January 18. Dr. W. R. Springstun, of Evansville, was the guest speaker. His subject was "Contagious Diseases." Sixteen members were present.

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Lake County Medical Society members met at Phil Smidt's Restaurant, in Whiting, on January 12. This was the annual joint meeting with the Northwest Indiana Dental Association, for which the dentists were hosts this year. More than one hundred members and guests were present. The guest speaker was M. H. Petersen, a member of the National Physician's Committee, whose subject was "Medical Legislation in the 81st Congress."

* * *

LaPorte County Medical Society members met at the Peacock Inn, in Rolling Prairie, on January 20. This was a business meeting, and forty-five members and two guests were present.

* * *

Madison County Medical Society members held a meeting on January 17, at the Anderson Country Club in Anderson. Fifty-one members were present, to hear Mr. Albert Stump, attorney for the state association, speak on "Pending Legislation in the General Assembly of Indiana."

* * *

Putnam County Medical Society members met at the College Inn, in Greencastle, on January 14. Dr. E. F. Boggs, of Indianapolis, spoke before the sixteen members who were present, on "Pericarditis."

* * *

Ripley County Medical Society members held a meeting at the American Legion Home in Batesville, on January 19. Twelve members and one guest were present for the dinner meeting and election of officers.

* * *

Shelby County Medical Society members met in Shelbyville on January 12. Sixteen members were present, and participated in a discussion of Blue Cross and Blue Shield plans, as well as a Department of Public Welfare Medical Plan.

* * *

Stenben County Medical Society members held a meeting on January 10, at Elmhurst Hospital in Angola. Election of officers and a business session were held.

* * *

Tipton County Medical Society members held a meeting in Tipton on January 12. Seven members were present for the election of officers and reports of committees.

* * *

Vanderburgh County Medical Society members held a meeting at the Hotel McCurdy, in Evansville, on January 11. A sound movie on "Kidney Function in Health," was shown by a representative of Lilly Laboratories. There were 108 members in attendance.

* * *

Wabash County Medical Society members held a meeting at the Country Club in Wabash, on January 19. Fourteen members were present.

* * *

Whitley County Medical Society members met in Columbia City, on January 11. Nine members were present to hear Dr. J. W. Jackson, of Indianapolis, speak on "Ringworm in Children."

WOMAN'S AUXILIARY to the **Indiana State Medical Association**

President—Mrs. William Morrison, Kokomo.

President-elect—Mrs. Truman Caylor, Bluffton.

Corresponding Secretary—Mrs. Charles Viney, Logansport.

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The House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association will meet at the Hotel La Fontaine in Huntington, on April 26 and 27. Hotel reservations must be made before April 1.

* * *

Haddon Hall will be the headquarters for the annual meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 6 to 10, 1949. Requests for reservations should be sent at once to Dr. Robert A. Bradley, chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.



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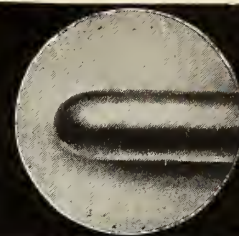
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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

SEARCHLIGHTS ON DELINQUENCY. By K. R. Eisler, M.D., managing editor; Paul Federn, M.D., chairman of the editorial board. This book is dedicated to Professor August Aichhorn, on the occasion of his seventieth birthday. 456 pages. Cloth. Price \$10.00. International Universities Press, New York, N. Y., 1949.

PSYCHODYNAMICS AND THE ALLERGIC PATIENT. By Harold A. Abramson, M.D., with a panel discussion. 81 pages. 7 figures. Cloth. Price \$2.50. Bruce Publishing Company, St. Paul and Minneapolis, 1948.

ESSENTIALS OF GYNECOLOGIC ENDOCRINOLOGY. By Gardner M. Riley, Ph.D., Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School, and head of the Gynecological Endocrine Laboratory of the University Hospital at Ann Arbor. 205 pages, with 35 illustrations. Paper. Price \$3.00. Caduceus Press, Ann Arbor, Michigan, 1948.

BLOOD TRANSFUSION. By Elmer L. DeGowin, M.D., Associate Professor of Internal Medicine, State University of Iowa; Robert C. Hardin, M.D., Assistant Professor of Internal Medicine, State University of Iowa; and John B. Alsever, M.D., Senior Surgeon, U. S. Public Health Service. 587 pages, with 200 diagrammatic drawings. Cloth. Price \$9.00. W. B. Saunders Company, Philadelphia and London, 1949.

MAYO CLINIC DIET MANUAL. By the Committee on Dietetics of the Mayo Clinic. 329 pages. Paper. Price \$4.00. W. B. Saunders Company, Philadelphia and London, 1949.

CLINICAL ASPECTS AND TREATMENT OF SURGICAL INFECTIONS. By Frank Lamont Meleney, M.D., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University, Associate Visiting Surgeon, Presbyterian Hospital, New York City. 840 pages, with 287 figures. Fabrikoid. Price \$12.00. W. B. Saunders Company, Philadelphia and London, 1949.

OBSTETRICS ANALGESIA AND ANESTHESIA—Their Effects Upon Labor and the Child. By Franklin F. Snyder, M.D., Associate Professor of Obstetrics and Associate Professor of Anatomy, Harvard Medical School. 401 pages, with 114 figures and 18 tables. Fabrikoid. Price \$6.50. W. B. Saunders Company, Philadelphia and London, 1949.

THE BUSINESS SIDE OF MEDICAL PRACTICE. By Theodore Wiprud, Executive Director and Secretary of the Medical Society of the District of Columbia, and Managing Editor of the Medical Annals of the District of Columbia. Second Edition. 232 pages, with 22 figures. Cloth. Price \$3.50. W. B. Saunders Company, Philadelphia and London, 1949.

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Division of Communicable Disease Control

MONTHLY REPORT—SEPTEMBER, 1948

Diseases	Sept. 1948	Aug. 1948	July 1948	Sept. 1947	Sept. 1946
Brucellosis	5	5	5	6	18
Chickenpox	19	5	48	12	35
Diphtheria	13	11	18	17	18
Dysentery, Unspecified	2	3	0	0	0
Encephalitis	4	2	3	8	7
Erysipelas	2	0	0	0	0
Food Infection	3	3	2	12	3
Impetigo	6	3	18	11	8
Influenza	16	2	3	53	20
Malaria	3	3	1	1	0
Measles	9	25	230	11	11
Meningitis,					
Unspecified	3	3	7	4	9
Influenzal	1	1	0	2	—
Meningococcal	1	1	3	0	—
Mumps	21	27	69	9	18
Pneumonia	29	10	21	27	10
Poliomyelitis,					
Paralytic	80	54	25	38	—
Non-paralytic	39	14	16	58	—
Unspecified	21	7	2	0	131
Rabies, Animal	31	60	82	0	—
Rheumatic Fever	1	1	2	0	0
Rocky Mt. Spotted Fever	3	2	2	1	2
Rubella	8	4	10	1	2
Scabies	10	0	0	0	—
Scarlet Fever	49	33	41	50	89
Septic Sore Throat	6	1	5	9	22
Tetanus	1	2	2	2	3
Tinea Capitis	2	1	6	6	0
Trachoma	1	0	2	0	0
Typhoid Fever	10	5	10	18	9
Whooping Cough	56	43	45	170	88
Pellegra	1	0	0		
Tuberculosis,					
Pulmonary	237	195	315	225	291
Other Forms	20	13	13	9	20

MONTHLY REPORT—OCTOBER, 1948

Disease	Oct. 1948	Sept. 1948	Aug. 1948	Oct. 1947	Oct. 1946
Brucellosis	6	5	5	10	19
Chickenpox	80	19	5	95	143
Diphtheria	47	13	11	43	48
Encephalitis	4	4	2	2	0
Influenza	16	16	2	46	18
Measles	19	9	25	24	26
Meningitis,					
Unspecified	1	3	3	5	7
Meningococcus	5	1	1	1	0
Pneumococcus	2	0	0	1	0
Staphylococcus	1	0	0	0	0
Lymphocytic choreo.	1	0	0	0	0
Mumps	67	21	27	19	18
Pneumonia	49	29	10	48	24
Poliomyelitis,					
Paralytic	38	89*	56*	29	0
Non-Paralytic	14	39*	14*	13	0
Unspecified	18	11*	1*	0	99
Rabies, Animal	43	31	60	14	0
Rheumatic fever	2	1	1	1	0
Rubella	1	8	4	6	1
Scabies	2	10	0	0	0
Scarlet fever	120	49	33	109	200
Tinea Capitis	6	2	1	65	0
Tuberculosis, Pulmonary	165	237	195	171	158
Other forms	5	20	13	23	6
Tularemia	3	0	1	1	2
Typhoid fever	11	10	5	3	21
Whooping cough	35	56	43	175	63
Enteritis	1	0	0	0	0

* Revised figures.

MONTHLY REPORT—NOVEMBER, 1948

Disease	Nov. 1948	Oct. 1948	Sept. 1948	Nov. 1947	Nov. 1946
Brucellosis	7	6	5	11	27
Chickenpox	368	80	19	311	424
Diphtheria	38	47	13	73	46
Dysentery, Amebic	11	0	0	0	4
Encephalitis	4	4	4	2	1
Erysipelas	1	0	2	1	4
Impetigo	9	0	6	13	6
Influenza	105	16	16	53	23
Measles	93	19	9	51	44
Meningitis,					
Unspecified	3	1	3	8	6
Influenzal	2	0	1	0	—
Meningococcal	1	5	1	3	—
Mumps	72	67	21	75	45
Paratyphoid	1	0	0	0	0
Pneumonia	65	49	29	42	29
Poliomyelitis,					
Paralytic	8	38	89	15	—
Non-paralytic	4	14	39	4	—
Unspecified	8	18	11	0	65
Rabies, Animal	54	43	31	29	—
Rheumatic Fever	1	2	1	0	0
Rubella	4	1	8	8	3
Scarlet Fever	136	120	49	252	280
Shigellosis	1	0	0	—	—
Septic sore throat	3	0	6	8	7
Tetanus	2	0	1	1	0
Tinea Capitis	6	6	2	51	0
Tuberculosis,					
Pulmonary	137	165	237	223	252
Other forms	6	5	20	23	10
Tularemia	10	3	0	5	14
Typhoid	3	11	10	7	6
Vincent's Angina	2	0	0	2	5
Whooping cough	68	35	56	274	109

MONTHLY REPORT—DECEMBER 1948

Diseases	Dec. 1948	Nov. 1948	Oct. 1948	Dec. 1947	Dec. 1946
Chickenpox	313	368	80	464	455
Diphtheria	45	38	47	49	62
Encephalitis	1	4	4	2	2
Impetigo	1	9	0	2	10
Influenza	15	105	16	33	21
Measles	118	93	19	217	36
Meningitis, Meningococcus	4	1	5	2	—
Meningitis, Unspecified	2	3	1	9	9
Mumps	112	72	67	106	36
Pneumonia	53	65	49	48	36
Poliomyelitis, Paralytic	5	9	40	11	—
Poliomyelitis, Unspecified	4	6	14	3	14
Rabies in Animals	65	54	43	29	—
Rheumatic Fever	3	1	2	0	0
Rubella	4	4	1	5	1
Scarlet Fever	217	136	120	227	281
Tinea Capitis	10	6	6	20	0
Tuberculosis, Pulmonary	158	137	165	145	116
Tuberculosis, Other Forms	10	6	5	17	2
Tularemia	23	10	3	9	47
Typhoid Fever	1	3	11	3	4
Vincent's Angina	1	2	0	1	5
Whooping Cough	46	68	35	180	99

THE JOURNAL

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NUMBER 4

MALIGNANT MELANOMA

A DISCUSSION OF SIXTY-FIVE PATHOLOGICALLY PROVEN CASES*

NATHANIEL D. EWING, M.D.

VINCENNES

THE malignant melanoma has gained an ominous reputation because of its tendencies to widespread metastasis from what is often a small, apparently innocent primary source. In adequately treated cases which have been recognized early the cure rate compares favorably with other types of malignant tumors. In many instances recognition of these tumors is not early enough to offer the patient a reasonable chance for cure.

In 1922 Bloodgood¹ introduced modern therapists to malignant melanoma by his pessimistic report of only one five-year survival in 200 cases. Much of this dismal attitude concerning the curability of melanomas has remained up to the present time. In recent years Adair,² in a series of 400 melanomas, reported a 33 percent five-year salvage for the cases which had received no previous treatment. Recently Tibor de Chohnoky³ reported a 42 percent five-year survival in a small group of operable (selected) cases. This brief résumé of the progress made since 1922 is encouraging.

INCIDENCE

The relative tumor incidence of melanomas varies with locality and the absolute incidence varies with race. There is no great difference in sex incidence. Most of the patients in this group came from rural areas, where the incidence of basal and epidermoid carcinomas is rather high. For this reason, melanomas occurred only once in every thirty-five skin neoplasms. On the other

hand, Pack⁴ states that melanomas are seen once in every five malignant skin lesions at the Memorial Hospital in New York City.

None of these sixty-five melanomas were found in members of the Negro race. Melanomas in American Negroes are rare indeed, although they are rather common on the feet of African Negroes living along the upper Nile Valley. Hewer⁵ associates the high incidence on the feet of these Negroes with infections introduced by thorns.

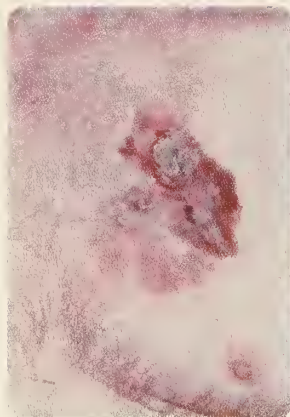
Beginning with puberty there is a steady increase in the incidence of melanomas with each succeeding ten-year period, when corrections are made for the population surviving in each decade. The absolute incidence is greatest between the ages of forty and sixty. The anatomic distribution of melanomas can quickly be summarized, as 40 percent of the cases occurred on the head and neck alone, 30 percent were rather widely distributed over the trunk, upper extremities, perineal area and thighs, while the remaining 30 percent were again concentrated in the areas below the knees. This "top and bottom" distribution deserves comment.

ORIGIN

Although obscure, the origin of the melanoma cell is fascinating. Soldan, Masson⁶ and Foot,⁷ by special staining techniques have shown that the origin of neval cells is from the tactile end organs and is therefore neurogenic. The low order of radiosensitivity of these tumors tends to uphold this concept since tumors of nerve origin are generally radioresistant. Certain phylogenetic

* Clinical material studied at the Ellis Fischel State Cancer Hospital, Columbia, Missouri.

Photo No. 1



Melanoma on the skin of the breast. Freckle-type. A radical mastectomy with wide excision of skin followed by grafting would be indicated here.

Photo No. 2



Melanoma on skin of the buttock. Wide, deep excision of the primary, followed by a radical groin dissection was done.

Photo No. 3



Small primary melanoma only 0.4 cm. wide located on the scapular region gave rise to bulky, axillary metastasis noted in photo No. 4. A dissection-incontinuity would be indicated in this case. The primary melanoma in photo No. 3 is on the left; just to the right is a tiny satellite nodule. The fawn colored nevus is benign.

Photo No. 4



phenomena further substantiate the association between nerve endings and melanin-producing cells. For instance, the cuttlefish, the chameleon, the squid, and various fish have melanin-producing cells under direct nervous control. Because of its origin this tumor possibly should be designated as a melanoblastoma; however, the term melanoma has come into more common usage and implies the malignant variant.

The transformation of quiescent moles into melanomas was commented on by Laennec and Virchow. Forty-three percent of these patients stated a mole had been noted for a variable period of time prior to the onset of malignant degeneration. It is generally asserted that repeated trauma to a mole may induce malignant change. Webster⁸ found ill-fitting shoes, belts and corsets to be a factor mentioned in thirty-six out of sixty-eight cases.

DIAGNOSIS

The clinico-pathologic features of a melanoma can assume a variety of forms, but in the main a pigmented, hairless lesion which begins to increase in size should be treated as a melanoma until proven otherwise. Often the lesion bleeds easily and sometimes itches. The lesion may tend to ulcerate and as it progresses the surrounding skin may become pigmented with a halo of soot-like particles. Later, satellite nodules may develop in the surrounding skin, and the regional lymph nodes eventually become palpable. By this time there are usually subclinical metastases beyond the regional node group and the disease is hopelessly advanced. These neoplasms rarely may spread by direct extension. They usually metastasize through the lymphatics and seemingly have

a predilection for the local intradermal channels (satellite nodules). They also metastasize via the hematogenous route more often than any other skin tumor. Visceral metastases usually make their presence known clinically as pulmonary or hepatic nodules, but no organ is immune to secondary emboli from this cancer. Pathology textbooks seldom fail to mention the fact that the myocardium may be the residence of metastatic melanoma. Ackerman⁹ found that the heart was involved in 50 percent of the cases autopsied. The average duration of symptoms of a patient who died from melanoma was found to be forty months in this series.

Among the less usual clinical types of melanomas is a nonpigmented variety known as an amelanotic melanoma. This lesion may resemble unhealthy granulation tissue. A flat or "freckle-type" malignant melanoma is occasionally seen. (See photos.) Melanotic whitlows make their appearance most often on the toes, and are characterized by a slate-blue to black lesion in the periungual or subungual skin. Melanomas arising in the eye are often associated with glaucoma and a fundus demonstrating a nontremulous detached retina. The diagnosis is seldom made early. Melanomas of the eye occur second to those of the skin in frequency. Following removal of the orbital contents, they have a peculiar characteristic of reappearing at distant sites after a remarkable latency. Metastatic melanomas are occasionally found in lymph nodes, although the primary tumor cannot be found by the most careful examination and history.

Lesions which simulate skin melanomas are pigmented papillomata which have become infected; benign, hairy moles; blue nevi of Jadassohn (blue

Mongolian spots); von Recklinghausen's disease; pigmented basal cell carcinomas; seborrheic warts; pyogenic granulomas and glomus tumors. Experience soon increases the accuracy of the clinician's impressions in differentiating these lesions.

TREATMENT

Patients with melanomas who have had previous inadequate treatment have a decidedly worse prognosis. In the cases in this series, 57 percent had had previous treatment, and of this group 46 percent were hopelessly advanced on their first visit. Of the remaining 43 percent who had had no previous treatment, only 14 percent of this group were so far advanced on their first visit that treatment was refused. The duration of symptoms in previously treated cases was thirty-five months, while in the previously untreated cases it was only fourteen months; thus the additional delay of twenty-one months is undoubtedly one of the significant factors affecting the prognosis. The various types of prior treatment are listed in Table I:

TABLE I

Type of Treatment	No. Cases
Electrodissection/small inadequate excision	19
Escharotics	7
Cautery	6
X-ray	6
Oral medicaments	3
Amputation/enucleation	2
Salves	2
Incision	1
Osteopathic adjustments	1

Examination of the table reveals that with two exceptions the previous treatment was not rational and simply wasted the patient's time.

The proper treatment of malignant melanomas should start with an understanding of the treatment of benign moles. Since by actual count on a large group of normal individuals an average of twenty moles per person is found, the prophylactic removal of all pigmented lesions from the skin would be impractical and foolish. The adequate removal of nonhairy, warty moles, containing black pigment, from the feet and regions of chronic trauma is strongly advocated. All pigmented moles removed should be examined by a pathologist. Any mole which has changed its character (i.e. ulceration, increase in size, deepening pigmentation, et cetera) should be removed widely.

Roentgenotherapy is to be condemned in the treatment of malignant melanomas. These tumors are not radiocurable.

The generally accepted treatment of malignant melanomas of the skin, and certainly the most rational one, is based on the premise that, by

and large, the majority of melanomas metastasize via the lymphatics and are temporarily arrested in the regional lymph nodes. Thus wide and deep excision of the primary lesion, followed by an *en bloc* removal of the regional lymph node-bearing area after a minimum interval of two weeks, is indicated. All suspicious moles are removed by means of a steel knife—never by electrodissection or cauterization. This method offers several distinct advantages, especially should the mole prove to be malignant on biopsy. When the lesion is removed by means of a steel blade the cosmetic results are better than when cautery is used. Immediate plastic reconstruction of any defect resulting from the excision is usually possible, and this is of utmost importance on the head and neck. Healing is more rapid. The pathologist is able to examine the limits of the specimen and is often able to determine with considerable accuracy whether or not the excision was adequate. Because of the more rapid healing and lower incidence of postoperative infection, the interval elapsing between the removal of the primary lesion and the regional node dissection is shorter when cold steel is used than when the lesion is extirpated by cautery. Amadon¹⁰ has advanced the idea that the use of the cautery may actually be harmful. Instead of "sealing lymphatics" by its coagulating effect, the cautery produces tissue steam which blows up the lymphatic channels to their greatest diameter.

The plan of treatment should be varied to suit the case. Should general constitutional factors, such as extreme age or advanced cardiovascular-renal disease, outweigh the desirability of a regional lymphadenectomy, the surgeon must then be satisfied with an excision of the primary lesion only. Metastasis beyond the limits of the regional lymph nodes is an absolute contraindication to anything more than the occasional palliative removal of a foully infected primary lesion. A regional lymph node dissection should never be performed unless the primary lesion is first adequately controlled (widely and deeply removed, with confirmation of adequacy of removal from the pathologist).

Lesions located on the head and neck offer a decidedly better prognosis than those arising on the lower extremities. There are two reasons for this. The classical radical neck dissection, in which the entire lateral neck compartment (including sternocleidomastoid, internal jugular, omohyoid and contents of the supraclavicular and submaxillary fossae) is removed, is much more satisfactory from the point of view of node removal than the radical groin and iliac dissection, in which nodes along the external iliac vessels must be removed piecemeal and the completeness of the dissection is seldom certain. The second reason is the fact that those patients with melanomas on the head and neck sought advice in an average

of sixteen months, while those with tumors on the lower extremities delayed their treatment until twenty-eight months had elapsed. This difference of twelve months might be responsible, in some measure, for the differences in prognosis between tumors arising on the head and neck and those whose origin is in the lower extremities.

Special problems are posed when the lesion is located near the midline of the body; then bilateral dissections are sometimes necessary. Bilateral groin dissections are commonly done but bilateral neck dissections are never attempted. If the melanoma is near the umbilicus it may metastasize to the liver by way of the round ligament. Melanomas arising in the eye or on the tips of the phalanges are at first contained in anatomical spaces, such as is an infection of these parts. The treatment is simply exenteration of the orbit or amputation of the digit. An axillary or inguinal dissection should follow the amputation, but no prophylactic regional dissection is indicated following removal of the orbital contents.

Another method of treating melanomas is based on the principle of dissection-in-continuity. It should be used whenever possible. If the lesion is located on the proximal arm, proximal thigh, the neck, breast, groin, scapular area, perineal region, or on the face below the level of the lower lip, then a dissection-in-continuity should be carried out. This is a one-stage procedure, in which the primary cancer is widely and deeply removed, along with the regional lymph nodes and the intervening lymphatic channels, by means of an *en bloc* dissection. This principle was first applied to cancer of the breast by Willy Meyer and W. S. Halstead at about the same time in 1894. It consisted of removal of the breast, the axillary lymph nodes and the intervening lymphatics *en bloc*. In 1908 E. Miles applied the principle to cancer of the rectum. In the Miles abdominoperineal resection of the rectosigmoid, the primary rectal cancer, the regional lymph nodes in the mesosigmoid, and the lymphatic vessels between the cancer and the first node arrest are removed in one specimen. In 1912 A. Basset applied the concept to cancer of the clitoris and shortly thereafter to vulvar growths. Cancers in certain regions or organs do not lend themselves to this principle. For instance, cancer of the upper air passages and accessory chambers are no longer surgically attacked. Cancer of the stomach is still being treated largely by subtotal gastrectomy, which amounts to little more than a local excision of the growth. A radical gastrectomy with removal of the entire organ, the six major groups of lymph nodes, plus the great omentum, would offer the surgeon a better chance of encircling the disease, but the present mortality, morbidity and nutritional complications are too formidable for the procedure of radical gastrectomy to be applied to

any but the more advanced carcinomas or the diffuse infiltrating types.

Many surgeons who do not hesitate to carry out radical mastectomies or resections of the stomach or bowel are loath to apply the same radical treatment to melanomas, yet they are dealing with a more aggressive type of neoplasm.

Some surgeons have commented on the danger of trapping tumor emboli between the primary lesion and the node group when the lymphadenectomy is performed too soon after excision of the primary lesion. In this group one patient had a melanoma removed from the lower extremity and within seventy-two hours a regional lymph node dissection was performed. Shortly thereafter he developed innumerable subcutaneous nodules between the site of the primary and the regional groin dissection. A hip disarticulation-amputation was refused. Melanomata removed before puberty are of such a low order of malignancy that a regional node dissection need seldom follow the excision of the primary. This intriguing observation that melanomas "step up" their malignancy as the individual passes puberty has tempted some investigators to treat advanced melanomas with thymus extract, pineal body extracts and other hormones, all rather unsuccessfully.

PROGNOSIS

Once metastasis in the regional lymph nodes is clinically palpable the patient's prognosis is invariably poor. Only three patients in this group survived over one year when a dissection was done for palpable nodes. Of those patients who received prophylactic dissections following excision, more than 30 percent are living after intervals of three to seven years. This compares favorably with results obtained in cancer of the tongue and is far better than the results obtained in cancer of the stomach.

It is the feeling of the author that no harm is done by incisional biopsy of melanomas, although it is not advocated. This impression has been gained through errors in biopsying lesions which were clinically thought to be pigmented basal cell carcinomas. Many others¹¹ concur.

The dopa reaction for melanuria appears to be of some prognostic significance. Of the sixty-five patients in this group, fifty-six were examined some time during the course of their disease for melanuria. Twenty-one were found to have a positive reaction and only 14 percent of these are alive. Of the patients who did not have melanuria, 50 percent are living. The percentage of patients who will demonstrate melanuria probably depends on the extent of their disease and the frequency with which the examination is performed.

SUMMARY

1. The incidence, distribution and clinical aspects of melanoma have been discussed.
2. The delay factors which obstruct adequate treatment of melanoma are stressed.
3. The relationship between delay and prognosis is emphasized.
4. The modern treatment of melanoma is described.
5. Comment is made on the biopsy of melanomas and the diagnostic value of melanuria.

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THE SYMPTOMS AND PROMPT DIAGNOSIS OF TUMORS OF THE GENITO-URINARY ORGANS*

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ALTHOUGH many ingenious methods have been devised for treating tumors of the genito-urinary organs with surgery, radiation and internal secretions, the end results have lagged far behind what appeared to be reasonable expectation. While there may be many reasons for this lag it is caused principally by difficulties inherent in the diseases and avoidable medical errors made at the time of the first contact between the physician and his cancer patient.

It is no exaggeration to state that when the first symptom of a genito-urinary cancer occurs 25 percent of the affected patients are incurable. In addition, there is a sizeable proportion of patients who are on the borderline of curability. If these individuals get the best treatment immediately they may be saved; if there is a delay in diagnosis, or if early treatment is ill-chosen their lives will be lost. As for the remaining patients who present symptoms of an earlier stage of disease, they more or less rapidly, at any rate steadily, approach incurability as time passes. Finally, to complicate the problem further, many of the more common tumors of the genito-urinary organs are deeply situated, often difficult to palpate, and can be seen, if at all, only indirectly by



roentgenograms or by examinations with special instruments such as the cystoscope.

For these reasons, when I was given the opportunity of speaking to you today on tumors of the genito-urinary organs, since consideration of the entire subject was impossible in the allotted time, it seemed probable that of all aspects of this important subject we could most profitably discuss "The Symptoms and Prompt Diagnosis of Tumors of the Genito-Urinary Organs."

WILMS' TUMORS

Wilms' tumors are congenital, embryonal, mixed tumors which arise from the kidney anlage. This is important clinically because tumors which arise at different developmental stages of the embryo may differ considerably in their natural history and may react quite differently to the same treatment. The majority are adenomyosarcomas. While they have been found in stillborn fetuses and about sixty cases in adults have been reported, the average age at the time of the first symptom is three years. They are exceedingly rare after the age of seven. While Wilms' tumors are uncommon in an absolute sense, statistical studies made at the Memorial Hospital of all malignant tumors in infants showed that relatively Wilms' tumors are second in frequency only to tumors of the eye. Whereas kidney tumors comprise only about 0.50 percent of all cancers of adults, in children 20 percent of all malignant tumors are Wilms' tumors.

Because these growths are surrounded by a dense capsule which separates them from both the kidney parenchyma and pelvis, urinary symptoms

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are rare. The majority of affected infants appear in good health although they may be slightly constipated or show indefinite malaise when suddenly a large tumor is discovered in one side of the abdomen—a condition indicating advanced disease. A palpable tumor is a most significant observation in either a child or an adult, but in a child it is of the greatest importance because it may be the only diagnostic sign. Inspection and percussion of the abdomen are often helpful. There may be a fullness at the costovertebral angle. Ballottement should enable the examiner to determine the retroperitoneal position of the growth. On the other hand, tumors may not be felt in children because of their adiposity. Also, in young children the kidney normally lies deeper in the pelvis than it does in adults, extending as low as the crest of the ilium.

The surface of the tumor usually feels smooth, although it may be lobulated in later stages. When necrosis or hemorrhage occurs into its substance, the mass may be soft and seem fluctuant, simulating the consistency of hydronephrosis. Flexibility of the tumor depends on the space available for movement within the abdomen. When first discovered the primary tumor is seldom adherent and frequently moves with respiration. The connective tissue capsule which separates the tumor from the kidney may form a groove, deep enough at times to be palpable through the abdominal wall. On the left side, such a groove may simulate the notch in the margin of the spleen.

Since the most painstaking general physical examination cannot establish the diagnosis, and because the tumor grows aggressively and metastasizes early, a urological examination should be made without delay. All clinicians should know that properly trained urologists with modern equipment can perform complete and detailed examinations without injuring the youngest infant of either sex.

Excretion urograms may or may not demonstrate a tumor in the kidney, but retrograde studies through a cystoscope not only should clarify this problem but also show the function of each kidney and, if present, detect bilateral tumor involvement. As soon as the primary tumor has been diagnosed a thorough search should be made for metastases. While these may be palpated as solid rounded tumors in almost any part of the body, especially the scalp, they are shown most frequently by roentgenograms of the lungs.

TUMORS OF KIDNEY PELVIS

Epithelial tumors of the pelvis comprise about 5 percent of all renal tumors. Since the mucosa of the kidney pelvis and ureter are of the same type as that of the bladder, tumors growing in these localities are similar. After a considerable period of "silent" development occult blood may appear in the urine. Usually later vague symptoms develop. If the tumor obstructs the pelvic outlet

there may be slight pain in the lumbar region. When pyelonephritis follows there may be slight elevations of temperature. At this time red blood cells usually are in the urine but no urinary change can be noted by the patient. After a time there is likely to be gross bleeding. This disease is likely to run a prolonged course with few symptoms because kidney function is likely to fail proportionately as obstruction by the tumor increases. In a large proportion of cases, when a urological examination establishes the diagnosis in the renal pelvis, other independent tumors are present in the ureter and perhaps in the bladder. Frequently the discovery of a tumor in or near a ureteral orifice leads to measures which disclose growths in the upper urinary tract. Proper treatment requires removal of the affected kidney with the ureter and that portion of the bladder wall immediately surrounding the ureteral orifice. Although as yet chemical examinations of the urine have failed to find a cancerigenic agent causing these tumors to form, clinical experience suggests that some such substance probably is excreted in the urine, because after one kidney and ureter have been removed there is frequent appearance of similar tumors in the remaining kidney.

PARENCHYMAL TUMORS OF KIDNEY

Tumors of the renal parenchyma in adults usually are adenocarcinomas which arise from kidney tubules. Most of these tumors grow toward the pelvis and ulcerate. As a result, the first symptom in about 85 percent of patients is hematuria. A close observer often can recognize hematuria of renal origin because it is total and painless. By "total" is meant that the blood is diffused equally throughout all of the urine in contradistinction to initial or terminal hematuria. Occasionally when bleeding is so profuse that clots form, the bleeding is not painless and patients may have colicky pains along the course of the ureter. Careful observers of the voided specimens in these cases may discover characteristic cylindrical blood clots 2-3 millimeters in diameter, easily recognizable as casts of the ureteral lumen.

The 10 to 15 percent of patients who do not have hematuria as the first symptom are especially unfortunate because their tumors grow through the renal capsule and infiltrate the perirenal tissues. They usually seek medical advice because of the loss of twenty-five to fifty pounds in four to six months, and at the time of their first examination are near the terminal state.

In addition to hematuria, pain in the lumbar region and a palpable mass constitute the classical symptoms of kidney tumors. When all three can be demonstrated the patient most likely is doomed.

The usual ache in the lumbar region associated with a kidney tumor probably is caused by increasing tension on the kidney capsule. If this pain suddenly becomes acute it indicates a hemorrhage into the growth. Discovery of the tumor mass by

either the patient or his physician is uncertain, since tumors of the upper pole are difficult to palpate and many kidney tumors metastasize before they become sufficiently large to feel. Since in these cases the most thorough general physical examination falls far short of proving the diagnosis and showing the function of the good kidney, a complete urological examination must be performed without delay.

Excretion urograms may show displacement of the affected kidney and characteristic alteration of its internal architecture due to tumor pressure but usually retrograde studies show them better and in addition are indispensable for individual functional tests, a requirement when the affected kidney must be removed.

After the primary tumor has been recognized one must conduct a careful search for distant metastases. These are usually blood-borne and can be found earliest in roentgenograms of the lungs or bones, most frequently the humeri. In an occasional instance the usual diagnostic measures must be supplemented by perirenal air insufflation or by aspiration biopsy of the growth.

TUMORS OF BLADDER

While pathologists are not in complete agreement regarding the classification of bladder tumors a satisfactory clinical grouping divides these growths into papillomas, papillary carcinomas and flat infiltrating carcinomas. It should be recognized that irrespective of their microscopic appearance all of these tumors are potentially malignant; in fact, I have seen papillomas metastasize to bone and show no histological criteria of malignancy, either in the primary bladder growth or in the bone metastasis. There is also evidence that papillomas may undergo malignant degeneration. At any rate these tumors, though innocent in appearance, must be discovered as early as possible and completely destroyed.

Bladder tumors also grow for a varying period without causing any symptoms. The patients are engaged in their usual occupations without any premonition of illness when they are suddenly shocked by seeing that they are voiding bloody urine. This spectacular initial symptom affects about 85 percent of all patients with bladder tumors. The importance of hematuria as a symptom cannot be overemphasized. In practically every case it indicates organic disease somewhere in the genito-urinary tract. One must never stop investigating until both the source of the bleeding and its cause have been clearly demonstrated. It should be remembered also that hematuria arising from tumors of the genito-urinary tract is always intermittent. A carelessly prescribed urinary antiseptic is likely to be followed by cessation of bleeding and the patient will be encouraged but the tumor will continue to develop, steadily diminishing his chances of recovery.

If the bladder tumor is not controlled soon after

hematuria has been noted, urinary frequency occurs, followed by dysuria. The symptoms of hematuria, frequency and dysuria occur in this order because growth of the tumor sooner or later outstrips its blood supply. Necrosis occurs and when the wall of a blood vessel is destroyed there is hemorrhage into the bladder. Also, in the neighborhood of a growing tumor there is infiltration of the bladder wall by inflammation or tumor. This increases the irritability of the bladder and decreases its capacity. Finally, after the tumor ulcerates it is not long before infection sets in, augmenting all symptoms and urination becomes difficult and painful.

In about 15 percent of patients with bladder tumors the first symptoms are frequency and dysuria. This occurs when the tumors are situated near the sensitive bladder outlet where irritation can be felt before the tumor breaks down and bleeds.

The diagnosis of a bladder tumor must be made by cystoscopic examination and by microscopic study of an adequate piece of the growth, because the most careful physical examination or the most exhaustive tests of the urine cannot demonstrate the true condition. The pathologist's report should be limited to a description of the submitted tissue because, for the following reasons, the urologist is better able to estimate prognosis in each case:—since most deaths from bladder tumors are caused by failure of the upper urinary tract due to obstruction and not to the tumors per se, the location of tumors in relation to ureteral orifices and the bladder outlet, apparent to the cystoscopist, cannot be determined by the pathologist; multiplicity of tumors, a factor which makes prognosis more grave, is not disclosed by microscopic study; finally, the amount of tissue usually removed through the cystoscope is but a small part of the growth and it is not rare to find bladder tumors composed of tissues representing two or three distinct grades of malignancy.

When the condition within the bladder has been thoroughly investigated a bimanual examination of the pelvis should be made, with the patient completely relaxed under anesthesia. If induration of any portion of the bladder wall can be detected in this way it is likely that the tumor has infiltrated through and beyond the bladder at that point. In the same manner, if there is palpable induration along the course of the vesical arteries and veins on either side there is considerable likelihood that tumor extension has progressed beyond the bladder through lymphatics.

In all cases excretion urograms should be made to show the condition of the upper urinary tract. These often show an astonishing degree of renal and ureteral change. At the time of the first examination we have found evidence of partial or complete loss of function of one or both kidneys in 35 percent of the patients. With few exceptions this was brought about by tumors obstructing the

ureterovesical orifices or by lymphatic metastases pressing upon and occluding the ureters in the pelvic or lumbar region.

TUMORS OF PROSTATE

Prostatic cancers are common. Probably 5 percent of all men who reach the age of sixty years develop the disease. In comprehensive studies of prostates removed because of benign hyperplasia nests of cancer cells have been discovered by the microscope in about 20 percent. The complete removal of the prostate is a practical operation which would cure the great majority of all patients if their tumors could be discovered sufficiently early. However, the tumors grow so insidiously that when discovered, in at least 95 percent of the patients, the condition is inoperable. Furthermore, it is likely that when prostatic cancers can be recognized by rectal touch the great majority are incurable. If the prostate of every man over forty were carefully palpated each year, if every suspicious nodule or firmness were aspirated and examined by a pathologist skilled in the study of aspiration biopsies, and if, whenever cancer cells were found the entire gland were removed with its capsule, I am certain that many lives now lost would be saved. I doubt, however, whether these suggestions are practicable in many communities. At any rate, as we see these patients when they first seek treatment almost every one is incurable even when the most skillful surgical, radiation or endocrine therapy is available.

The majority of prostatic cancers grow for a long time without causing any symptoms. When they do occur, the symptoms are those of slowly progressing obstruction of the bladder outlet. It may be noted at first that after urination the last few drops cannot be expressed and they seep on the underwear. Later, occasional nocturia occurs. Then it is discovered that when voiding for the first time in the morning urination starts hesitantly. Before long the stream becomes slower and it can be maintained only by a conscious effort. Frequency, dysuria, overflow incontinence or complete obstruction due to tumor growth are associated with hopeless stages of the disease, as are pains in the perineum, penis or sacral region. Unilateral sciatic pains in a man over sixty are suspicious, while bilateral sciatica in such a person is pathognomonic of a prostatic cancer.

A presumptive diagnosis of a prostatic cancer is usually made when rectal palpation reveals an enlarged, densely indurated, irregularly shaped gland. In most cases the tumor, in addition, extends beyond the gland in the direction of the seminal vesicles and laterally to form attachments to the bony pelvis. Because the most experienced examiners are likely to make diagnostic errors in at least 10 percent of their patients when they depend on rectal palpation only, these findings

should be substantiated by histological studies. I am able to use the comparatively simple aspiration biopsy because the Memorial Hospital pathologists are skilled in the diagnosis of tumor smears. Elsewhere incisional biopsies have proved most satisfactory.

Assay of the serum acid phosphatase is a useful specific test in the diagnosis of prostatic cancers and in the classification of these patients after the diagnosis has been made. The prostate gland is the only tissue in either sex which contains large quantities of acid phosphatase. This substance, however, does not appear in the serum as long as the tumor is confined within the capsule of the gland. A man, therefore, with a proved prostate cancer and a negative assay for serum acid phosphatase is likely to be in an operable condition, whereas a patient with a positive test for serum acid phosphatase not only has a prostatic cancer but also has metastases.

Alkaline phosphatase is not specific to prostatic cancer but the quantity of this substance in the serum is an accurate measure of the reaction of the bones to an irritant. Among other possible irritants is metastatic prostatic cancer.

Further diagnostic study of these patients calls for excretion urograms because the ureters are often obstructed. A roentgenological search should also be made for distant metastases which are found most commonly in the bones and lungs.

TUMORS OF THE TESTICLES

Tumors of the testis are usually found in young men. They are difficult to diagnose. This is unfortunate because the great majority are exceedingly malignant and metastasize early and widely. I know of no tumor which causes the patient to seek medical advice sooner. From our records of more than a thousand testicular tumors we found that 43 percent of the patients visited physicians within two months of the discovery of the condition but, largely because of delay in making a correct diagnosis, 89 percent of these young men had metastases before appropriate treatment was given.

Testicular tumors are seldom painful. There may be a dull ache in the inguinal region caused by drag on the spermatic cord but easily relieved by a suspensory. Not infrequently the affected testis is traumatized and a mass is discovered. Often the trauma is thought to be the cause of the growth and many suits for compensatory damages result. Probably the majority of these tumors grow from testicular tubules situated most often in the rete testis. While trauma, therefore, does not cause the tumor, testes in which tumors are present probably are traumatized with special frequency because they are larger and heavier and are likely to hang lower and cannot be so quickly removed from danger by muscular reflexes.

Most patients with testicular tumors first notice

a hard swelling of one testis. Occasionally the first symptom arises from a distant metastasis. This is more frequent when the testis has not descended from the abdomen and its enlargement is concealed.

In a disease which is so likely to prove fatal in a short time it is essential that a correct diagnosis be made without delay. One should therefore examine every intrascrotal swelling with the determination that a cancer must be recognized or definitely excluded. All of the patient's clothing must be removed. After palpating the scrotum with the patient standing, in order to discover a varicocele if it is present, the examination should be continued with the patient in the horizontal posture.

Inspection shows a unilateral swelling in the scrotum. Usually the overlying skin is normal but if the tumor is large the skin appears tense and glazed. In one series of cases nearly 20 percent of the testicular tumors were originally diagnosed as hydroceles. Hydroceles and testicular tumors should be readily differentiated by inspection because hydroceles extend upward and cause a swelling of the skin at the base of the penis which makes the penis appear shorter, while a tumor of the testis is confined to that organ and does not cause an apparent shortening of the penis. Palpation should be gentle for fear of disseminating metastases. It is fundamental to establish at first whether the swelling is of the epididymis or testis. Though closely connected anatomically, these structures are different embryologically and are subject to different diseases. A testicular tumor retains the shape of a normal testis because of the resistance to expansion of the dense tunica albuginea. Usually the tumor feels stony hard and almost as heavy as lead. This remarkable density is characteristic of the great majority of testicular tumors and can be recognized even when the growth is small. In complex tumors the palpating fingers may identify stony hard nodules of cartilage or bone, or sink into cystic depressions. Sometimes the tumors are surrounded by varying amounts of fluid which prevents accurate palpation. This fluid can be aspirated safely providing the tunica albuginea is not punctured. Usually this fluid is the commonly found, clear, amber hydrocele fluid, but occasionally it is bloody. Bloody fluid indicates that the tumor has infiltrated the epididymis because all of the testis is covered by the impermeable tunica albuginea.

In most cases the spermatic cord is quite normal; occasionally it is hard, inelastic and enlarged because of direct extension of the tumor. Sometimes if the primary growth is large, pulsation of the spermatic artery may be detected. Inguinal adenopathy is present only after the scrotal skin has become involved. One should never aspirate or incise a testicular tumor to obtain material for microscopic study. These operations destroy nat-

ural barriers and permit rapid extension with ulceration of the scrotum.

After examining the primary tumor the abdomen should be carefully palpated. The most experienced clinician may sometimes be doubtful of the nature of a testicular swelling but if a characteristic mass can be discovered in the abdomen above the affected testis the diagnosis is clear. The earliest demonstrable metastases from testicular tumors usually involve lymph nodes situated in the angle formed by the aorta and the renal artery on the same side as the enlarged testis. These metastatic masses are rounded, fixed and retroperitoneal. While not tender to moderate pressure they cause pain in the lumbar region even before they become palpable. It is important, therefore, to ascertain whether the patient has been troubled with a backache. We have found excretion urograms useful in demonstrating abdominal metastases because they sometimes displace the kidney or upper ureter. Further lymphatic extensions involve the epigastric region where enlarged nodes seldom can be palpated. The disease then follows the prevertebral nodes cephalad in the thorax and accompanies the thoracic duct to the left supraclavicular fossa, where the well known signal node may be found enlarged and firm. This node can best be discovered if the patient stands or sits upright. In all cases the breasts should be examined because gynecomastia due to hormonal disturbance may be present. Its presence usually makes the prognosis more grave. Finally, roentgenograms should be made of the lungs in search of blood-borne metastases. When present they appear as dense, round shadows. The fact that they are always round, irrespective of their size, indicates their origin in the round lumen of a vein. We have found metastases in the lungs of one-third of all patients who showed lymphatic metastases.

TUMORS OF PENIS

Cancers of the penis develop from chronic irritation beneath a tight prepuce. Hard, inspissated smegma is a potent mechanical irritant and probably there is chemical irritation as well from fatty acids. Jews, who practice ritualistic circumcision of all boy babies at the end of their first week of life, are immune to penile cancers. Mohammedans, who circumcise their boys at the age of ten years, are relatively free from penile cancers. However, the fact that Mohammedans, circumcised at ten, sometimes have cancers of the penis, indicates that the precancerous changes can become well established at an early age and may progress to definite cancer formation even when the cause has been removed comparatively early in life. I have performed amputations on more than thirty patients on whom circumcision had been performed forty or more years before the growth appeared.

It is well to remember also that penile cancers are not confined to elderly men. Forty percent of

our patients were less than fifty years of age when the disease was found. One patient with an extensive tumor was a boy of seventeen.

Although most patients with penile cancers have suffered from chronic irritation for a number of years, after the tumor has formed they are usually aware that the condition has changed for the worse. They have burning or stinging sensations at or near the end of the penis; from beneath the prepuce may come a discharge which is serosanguineous and has the foul odor of necrosis, or they may see part of the growth, described as a small sore, red spot or wart.

The early signs of a penis cancer depend largely on whether or not the prepuce can be retracted so that the parts can be examined. It is well to begin the examination by palpating the glans through the prepuce to detect induration. If the prepuce can be retracted one sees either a papillary overgrowth or a flat tumor which feels hard. Ulceration is almost always present. If retraction of the prepuce is impossible the first signs are usually those of a more advanced disease and a large part or all of the glans and prepuce may be densely indurated.

In every case the diagnosis of a cancer of the penis should be made by a microscopic examination of a portion of the growth. I know of no other part of the body where the same disease can appear so different or where different diseases can so closely resemble one another.

Unfortunately, it seems to be much easier to take blood for a serological test than to make a tissue biopsy. As a result the patients, not infrequently seen with both a penis cancer and a positive serological test for syphilis, seem to be especially unlucky because with few exceptions they are treated for months for syphilis while their cancers spread.

After the primary lesion has been examined one should search for metastases. These are usually discovered first in the lymph nodes of the subinguinal regions. Before administering radical therapy it is usually best to prove their malignant involvement by aspiration biopsy or removal of a suspiciously enlarged, hard node.

TUMORS OF SCROTUM

Epithelioma of the scrotum, or chimney sweeps' cancer, is of special interest because it was the

first industrial cancer to be described. While there are only a few chimney sweeps in this country there are many workers with other cancerogenic substances such as lubricating and fuel oils, tar, paraffin and certain ashes. In addition, protracted self-medication with arsenic compounds or tar pastes has led to scrotal cancers. After the work clothes of these men have been saturated with cancerogenic materials for twenty-five years or more a warty growth may appear on the scrotum, usually on the left side.

The patients usually complain at first of itching of the scrotum which fails to respond to all types of home remedies. This is followed in four to six months by a small but steadily enlarging papillomatous lesion which only too often is neglected for six to eighteen months, when metastatic invasion of one or both inguinal regions becomes evident. Here again no time should be lost in speculation or in the empirical use of local remedies. Without delay the diagnosis should be made by microscopic examination of an adequate specimen of the tumor.

SUMMARY

In even a rapid survey, such as this, of the symptoms and prompt diagnosis of tumors of the genito-urinary organs one can recognize that certain procedures are conducive to early recognition of these diseases and the saving of many lives, while other practices take from the patient whatever chance of survival he may have had. It is of the greatest importance to examine patients with the idea in mind that their disease may be a cancer. Do not be satisfied with a diagnosis based on probabilities. Whenever possible in all suitable cases, prove the diagnosis objectively. This is best accomplished by microscopic study of the growth. It can be done in the great majority of genito-urinary cancers. If the patient requires the services of a specialist, and this is frequently the case, not only do not delay your decision to refer him to the urologist of your community, but insist even against his remonstrances that he be examined at once. A strict observance of these principles will save patients otherwise doomed and will increase one's satisfaction in dealing with these deadly diseases.



THE RATIONAL THERAPY OF CARCINOMA OF THE CERVIX

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THE therapy of carcinoma of the cervix is the greatest single accomplishment of radiation therapy. Therefore, every doctor doing radiology is ready to discuss it on the least provocation. The patient who has been successfully treated for carcinoma of the cervix is very often the only bright spot in a day spent in giving palliative treatment to a succession of patients hopelessly ill with cancer.

PURPOSE

This paper is written in the hope of stimulating more forethought in designing a plan of treatment for the individual with cancer of the cervix. Recent statistical studies¹ from several large cities show overall cure rates of from 35 to 45 percent. This is somewhat better than the country-wide cure rates. Why should this be, when the same weapons—aseptic surgery, radium and x-ray—are available to all? A similar situation is seen when the 1925 and the 1945 figures from large centers are compared. Writers from these centers feel that the increased number of cures is due principally to more judicious selection of the plan of treatment to fit the individual case. It seems very likely that the country-wide statistics could be similarly favorably influenced by plans tailored to fit the individual.

HISTORICAL

Carcinoma of the cervix as an entity separate from other malignancies of the uterus was first recognized in the mid-1800's, with the birth of cellular pathology. Favored treatment at this time was extensive cervical cautery or amputation of the cervix via the vaginal route. In the late 1800's, when abdominal surgery became practicable, Wertheim and others made the first important forward step with their radical surgical procedures, including complete removal of the pelvic lymph nodes. Cures with this surgery were not numerous except in the very early cases. The associated morbidity and mortality from the surgery was high. The mortality was between 15 and 20 percent. Today the radical operation is performed with practically no morbidity and less than 5 percent mortality. Meigs² recently reported ninety-one cases with no mortality. The earliest records of radium usage were in 1903, when three different people reported its use in individual cases. Most modern radium techniques are derived from the French, and especially from Regaud of the Curie Institute in Paris.

EVALUATION OF THE PATIENT

The patient presents herself with a proven carcinoma of the cervix. Surgery in the form of total hysterectomy or hysterectomy with pelvic lymph node dissection may be the treatment of choice. Radium applications as the high intensity of the cervical tandem and vaginal colpostats, or the low intensity of long, low-content needles inserted into the parametrium, or x-ray by large portals of generalized pelvic irradiation or trans-vaginally by means of cones applied directly to the lesion, may be indicated. More likely a combination of these methods will be needed. What combination will we need in this patient to give her the best opportunity for cure? This question is to be answered only by critical evaluation of the patient with special regard to certain points.

PRINCIPAL COMPLAINT AND DURATION

The chance for survival diminishes about 1 percent for every week of symptoms. The most common early symptom is bleeding, especially with intercourse. In some cases leukorrhea may precede bleeding by several months. In such cases the lesion has probably arisen from within the cervix and is moderately advanced at the original examination. Pain is an indication for intensive treatment. Pain in the pelvis or in the renal areas is indicative of far advanced disease, and the chance for survival will probably be less than 5 percent. It must be remembered, however, that the pain may be due to secondary infection in the tumor and not necessarily due to malignant invasion of adjoining structures.

LOSS OF WEIGHT

Significant weight loss is an indication of advanced disease.

PAST HISTORY

We are interested principally as to previous or present pregnancy. The relaxed vaginal vault of the parous patient allows better application of radium and also allows the use of intravaginal cones. Intravaginal x-ray cones are not usually practical in nonparous women. The statement is often made that carcinoma of the cervix is a disease of women who have had multiple pregnancies. However, 10 percent of the cases of carcinoma of the cervix occur in nulliparous women, and this must be approximately the percentage of nulliparous women in the general population.

PHYSICAL EXAMINATION

A general physical examination should be done to discover other disease processes that might unfavorably influence the disease or the ability to tolerate treatment. The chronic systemic diseases definitely decrease the cure rate. Tuberculosis, diabetes and syphilis particularly should be looked for.

Local examination of the pelvis includes external palpation of the inguinal lymph nodes, vaginal palpation and inspection, and rectal examination. The size of the uterus is estimated as normal or enlarged. The degree of hardness of the cervix and the amount of involvement is observed.

The amount of fixation of the cervix is determined. Through the vaginal speculum, the size of the ulcer and the amount of extension away from the cervical os is estimated. Also, the amount of involvement of the vagina, the vesicovaginal septum, and the rectovaginal septum is estimated.

The rectal examination gives the most valuable index of the amount of fixation of the cervix to the surrounding tissues. Enlarged pelvic lymph nodes are very easily palpated and the size of the involvement estimated. Tenderness of these nodes should be noted. If they are tender, they may well be inflammatory instead of malignant.

LABORATORY STUDY

This should include complete blood counts, for two reasons. One is to detect any anemia. The other is to have a fairly normal standard for evaluation of radiation effects. Also, routinely, chest films and intravenous pyelograms should be included. Pyelogram showing lower ureteral pressure is evidence of advanced disease. (See Figure I.)

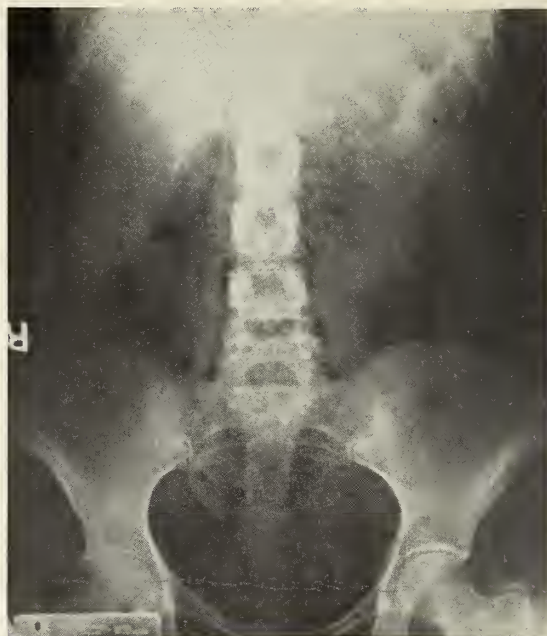
With this information assembled, a definite treatment plan is worked out, at least in broad outline. Most cases should have their treatment directed toward a cure, because at times apparently hopeless cases have been found ten years later with no evidence of disease. I wish to emphasize that the original treatment plan should be adhered to as closely as possible, and changes made in it only for definite reasons.

GROUPING OF PATIENTS

With this data we are ready to group the patients. Ninety-five percent of them will fit into one of the following three groups:

Group I—Those who are probably curable by radium or radical surgery alone. These are cases in which the disease is definitely localized to the cervix and the cervix is freely movable. The maximum extent of the malignancy will be less than two centimeters away from the cervical os. This group will constitute about 10 percent of the cases one sees.

Figure I



Intravenous pyelogram showing involvement of the lower ureters by carcinoma of the cervix. The right side shows brilliant pelvic and ureteral visualization as a result of delayed emptying due to lower ureteral pressure. On the left side there is total suppression of dye excretion with more advanced involvement.

Group II—Those who should have x-ray first, followed by radium, with radium still occupying the important place in the treatment plans. These will be cases with large local lesions and some fixation of the cervix, or small nodes palpable in the adnexal areas.

Group III—Those in which x-ray will be the principal therapeutic weapon and radium will be used in small doses, if at all. These will be the cases with advanced lesions of the cervix and large pelvic masses. This group will comprise about 30 percent of the patients seen.

It may be noted that pathologic grading as a part of treatment plans has not been mentioned. In general terms, Grade I lesions are radioresistant and Grade IV lesions are radiosensitive. Conversely, though, Grade IV lesions may be less curable due to their tendency to recur. The implications as to curability are so slight that pathologic grading is largely disregarded in treatment plans. Adenocarcinoma of the cervix will be discussed later. Some recent work on serial biopsies during treatment may prove to be of considerable aid in deciding on the radiocurability of the individual lesion.

SURGICAL TREATMENT

Total hysterectomy as a treatment for biopsy-proven carcinoma of the cervix will not accomplish

cures in the maximum number of cases. There is no reason to believe that hysterectomy without pelvic lymphadenectomy is more effective than mastectomy without axillary lymphadenectomy. Occasionally, a carcinoma *in situ* is removed when a hysterectomy is done for other disease. This is usually the only treatment necessary.

Hysterectomy, plus pelvic lymphadenectomy, is technically a difficult operation, but has a cure rate equal to radiation, where indicated. Its principal advantages are: 1. It removes the cervix, which could be the site of a second carcinoma if cured of the first one. 2. It is much less time-consuming to the doctor and to the patient. 3. The unpleasant side-effects of radiation therapy are avoided.

The operation, according to Meigs,² may be done in young, slender women who are good surgical risks. The lesion should not involve the vagina for a greater distance than one centimeter from the cervix. The pericervical tissues should not be involved by direct extension.

In well trained hands, the operative mortality should be less than 5 percent, and if the above criteria are followed, the cure rate should approach 75 percent.

Brunschwig³ has recently reported a radical pelvic evisceration operation for cure of advanced pelvic carcinoma. He has performed the operation twenty-two times, with 23 percent surgical mortality, and with some cures. The application of this type of surgery would be limited, but it probably offers a chance for cure in patients who are otherwise incurable.

RADIATION THERAPY

A short discussion of the physics of x-ray and radium and of their biologic action is necessary before proceeding. The unit of x-ray and radium dosage is the roentgen, usually referred to as "r." It is a quantity of energy just as the calorie is a unit of heat. The ability of x-rays to ionize air is utilized in establishing this measure of quantity.

Another factor is necessary in the full definition of quantity. That is the time factor. For instance, a given source of radiant energy at a certain distance will give a certain number of roentgens in a minute, or five minutes, or an hour.

This brings in the factor of intensity of radiation. We will suppose a patient with a bursitis of the knee, who is advised to apply heat to it. He might go home and apply a red-hot iron to it, giving it a lot of calories in a second. That's high intensity. Or, he may go home and apply a heating pad for an hour. That's low intensity. A somewhat comparable situation is radium and x-ray. The radium as used here is the high intensity of the iron, and the x-ray is the low intensity of the heating pad. The time interval in hours and days for the administration of a certain number of roentgens is important.

Average tolerances of various tissues in the pelvis have been fairly well established. The uterine wall will recover from 25,000 r. given in less than one week. The vagina will tolerate well over 10,000 r. in one week. The bladder is also fairly radioresistant. The rectum will tolerate about 8,000 r. in a period of two to three weeks. A minimum of 5,000 r. given to the entire tumor in less than thirty days is necessary for cure. Therefore, all of our efforts are directed toward giving the entire tumor over 5,000 r. in less than thirty days, without exceeding the tolerance of the rectum.

Group I—It was originally stated that these cases were the extremely early cases where the local lesion extended no more than two centimeters from the cervical canal. Also, there was no evidence of pelvic lymph node enlargement. Symptoms were present less than two months.

The average distance of the rectum from the radium source is two centimeters, therefore the maximum extent of the cancer should be no more than two centimeters from the radium if a cure is to be achieved without risking damage to the rectum. In this group, radium will cure the cancer in about 75 percent of the cases. Many men give postradium x-ray to the broad ligament areas, especially in young women. I doubt that this is necessary as a routine.

Group II—In this group the lesion is larger but there has not been a massive spread outside of the cervix. Usually, the pericervical tissues are invaded. There may or may not be enlargement of pelvic lymph nodes, but the involvement is not extensive. The duration of symptoms is longer.

X-ray is given first, with the central beam directed not to the cervix, but to the adnexal areas. The cervix itself gets only the less intense x-ray at the margins of the portals. The dosage is carried to a mild to moderate blistering effect on the skin. The reasons for preliminary x-ray are: 1. Experience has shown that these larger lesions have probably spread into the pelvic lymph nodes. 2. Lesions of this size are very likely to be secondarily infected, and inflamed tissues tolerate the high intensity caustic action of radium very poorly. X-ray clears up the infection very nicely. 3. The primary lesion shrinks quite markedly and is more likely to be confined to the two centimeter effective radius of radium. The last reason, I believe, is the most important.

The usual procedure is to wait about three weeks after the completion of the x-ray series before applying the radium. At this time the cervix is usually healed and the lesion is not grossly visible. The vaginal vault will be somewhat contracted and the application will be difficult. The much higher salvage rate justifies the extra trouble. Approximately one-third of the

patients in this group will live five years or longer.

Group III—This is the advanced disease group with frozen pelvis. Surprisingly enough, even in this group, a small number (3 to 5 percent) can be salvaged. The extent of the disease is mapped out as fully and carefully as possible, and the entire area of involvement is cross fired with as many portals of x-ray as the pelvic body surface will accommodate. The number will usually be six. The dosage is carried up to tolerance as calculated from depth dose tables and the reaction of the patient. Later, a small amount of radium is applied, but the dosage is held at a minimum, so that most of the tissue tolerance can be used in giving deep x-ray therapy.

SPECIAL GROUPS

Carcinoma of the cervical stump.—A certain number of people who have had a supracervical amputation of the uterus will develop a carcinoma of the stump. This makes treatment more difficult due to the shortness of the cervical canal and consequent inability to insert and secure adequate radium applicators. Also, the malignancy may involve the peritoneum earlier by direct extension up the cervical canal.

The treatment course will usually be one of expediency. I feel that if the lesion is sufficiently localized, high voltage x-ray through an intravaginal treatment cone is indicated, with the cone directed in various angles so that no single segment of the bowel is over-irradiated.

If the lesion is not thus localized, a short radium tandem and vaginal colpostats may be used. The close proximity of the bowel to the amputated cervix makes bowel complications from the radium much more likely.

PREGNANCY

Here the treatment varies, depending on the trimester of pregnancy. In the first trimester, the patient is treated as if she were not pregnant. A full course of x-ray about the pelvis is given. This will cause fetal death, an abortion will occur in about three weeks. The x-ray is followed by radium, as in the ordinary case.

During the second and third trimesters, abdominal hysterotomy with evacuation of the uterus is performed. This is followed by x-ray and radium therapy as indicated. The welfare of the baby is disregarded in treatment plans.

OBESITY

This is mentioned separately because in the extremely thick patient x-ray therapy is almost worthless. Certainly not enough x-ray will reach the tumor to effect a cure. When this situation exists, I usually give radium immediately, if there isn't too much secondary infection. If secondary infection exists, a course of sitz baths and penicil-

lin for five to ten days is prescribed. The radium is given usually in two doses, separated by one week, and dosage of the order of 7,000-8,000 roentgens at two centimeters from the cervical tandem is administered.

INVOLVEMENT OF THE VESICOVAGINAL OR RECTOVAGINAL SEPTUM

This occurs usually in the late stages, but occasionally an early case will show such extension. In these cases, the use of long, low-content radium needles, in addition to the routine treatment, may produce a cure which would be otherwise unobtainable. It is in this group that a high incidence of fistula is to be expected as a natural consequence of an earnest effort toward cure. The fistulas are usually secondary to malignant destruction of the involved tissues.

ADENOCARCINOMA OF THE CERVIX

This poses a separate problem because of the low inherent radiosensitivity of adenocarcinoma in general. I believe that in these cases the radium dosage and x-ray dosage must be carried right up to the tolerance of the rectum. In these cases it is likely that radical hysterectomy following the radiation therapy is justified.

COMBINATION OF RADIATION AND SURGERY

When is hysterectomy justified following radiation? The above is probably one instance.

A definite indication for surgery is the patient who has a local recurrence after adequate treatment. This patient's tissues will very likely not be able to tolerate a second series of intensive treatment. Also, it is likely that her lesion is one of the rare radioresistant ones.

Another patient who deserves surgery is the patient who has a suggestive mass in the pelvis but no definite evidence of recurrence. If on repeated examination this mass seems to become more prominent, and the patient is not doing as well as might be expected, exploration and radical hysterectomy are indicated.

MECHANICS OF IRRADIATION

The actual mechanics of radiation administration is a complicated procedure. Dosage should be such that the rectum will not receive more than 8,000-10,000 r. in two months, including x-ray and radium. It should be such that the entire tumor area gets around 6,000 r., and possibly a little more if treatment is extended for a two month period.

Radium dosage depends on the type of applicators, the amount of filtration, and their position within the pelvis. I usually insert a tandem containing 40 milligrams of radium, filtered by 1 millimeter of platinum inside the cervical canal. Three containers are placed in the vaginal vault, if possible. These consist of two colpostats con-

taining 10 mgms. and a cross-arm attached to the tandem, containing 5 mgms. The vaginal applicators have a slightly heavier filtration than the cervical tandem. Films of the pelvis are taken following the insertion and if satisfactorily placed, the dosage at a point 2 cms. from the cervical canal is calculated from Patterson and Parker or Quimby charts. With this technique a total dosage of 5,000 mgm. hours is usually about right in the average case. If the entire treatment is to be with radium, a larger total dose will be necessary, and it is advisable to divide this into two equal fractions given ten days apart.

The carcinoma cannot be divorced from the body and here, as in other disease, the patient needs to be treated. The psychic preparation of the patient is important. As long as there is a chance for cure the condition must be fully explained to the patient. This is necessary in order to gain the patient's confidence in the days ahead. She will usually be discouraged for a few days, but as she sees brighter days ahead her morale improves amazingly.

Vitamins, iron, liver and sedatives will usually be required during treatment to combat radiation effects.

Transfusions are extremely valuable, especially in the presence of anemia and chronic bleeding from the vagina.

COMPLICATIONS

A certain morbidity is inherent in the treatment of carcinoma of the cervix whether the treatment is surgical or radiation. Serious complications will occur in approximately 3 to 5 percent of the patients adequately treated by irradiation.

The most common and most severe complication is rectal ulcer and stricture. Rectal bleeding may be excessive. These ulcers may not heal for years and at times segmental colectomy may be necessary where bleeding is prolonged or intestinal obstruction occurs.

An amenable but often annoying aftereffect is pyometritis. This results from cervical stenosis and retained uterine secretions. Complaints are of midline tenderness and cramps simulating menstruation. Treatment is dilatation of the cervix.

The most confusing and spectacular condition is the so-called radium parametritis. This is best illustrated by a case. A young woman had routine treatment with radium and x-ray. She came back four months later with intractable pain in the pelvis. Examination showed a frozen pelvis. She was sent home to die, with lots of morphine. Six months later she returned with no pain and her pelvis was better. Today she is perfectly well and she has no complaints. This type of thing happens often enough that one is not justified in giving up until the patient goes into uremia.

Figure 11



Method of calculating radium dosage from an antero-posterior film of the pelvis. Figures are in gamma roentgens and are obtained from charts of Quimby, and Patterson and Parker.

	Dosage 2 cm. to right of cervix (10 hr.)	Dosage 2 cm. to left of cervix (10 hr.)
Cervical tandem 40 mgm.	570 r.	570 r.
Cervical cross-arm 5 mgm.	50	50
Right vaginal colpostat 10 mgm.	145	40
Left vaginal colpostat 10 mgm.	40	145
Total dosage in 10 hours	805	805
Dosage in 75 hours	6,035	6,035
(This was amount administered)		

The course of the patient may exactly simulate the course of far advanced carcinoma.

Rectovaginal and vesicovaginal fistulae do occur at times, but at least 95 percent of these are secondary to carcinoma invading the septum. The carcinoma is destroyed and the remaining tissues are so thin that fistula results. If the carcinoma is cured, most of these fistulae will close in two to three years by gradual contraction of scar tissue.

SUMMARY

1. The purpose of this paper has been a plea for individualization of treatment to fit the case and its requirements.
2. The criteria used in selecting treatment have been given.
3. Several special categories have been mentioned, with a brief outline of treatment to fit.

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THE PROBLEM OF CARCINOMA OF THE BREAST*

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EVANSVILLE

CARCINOMA of the breast is the most common type of malignancy encountered in the female.¹ In 1940 Dorm estimated that carcinoma of the breast accounted for 26 percent of malignant disease occurring in white women.² Thirty-seven out of every one thousand women who reach maturity will become victims of this disease, and each year more than fifteen thousand women in the United States die as a direct result of cancer of the breast.

Cancer of the breast is a disease which concerns the physician, the surgeon and the radiologist alike. Each of these groups has an important role in the care of patients who are victims of this disease. However, it is the general practitioner to whom most women will go for advice when an abnormality of the breast is noted, or when they desire a routine examination. That the advice given is not always good is affirmed by the fact that Haagensen³ found that 27 percent of the cases of carcinoma of the breast seen at Presbyterian Hospital had been given faulty advice by the physician who initially found the abnormality in the breast. The value of routine examination of the breast is well established, and probably from 3 to 5 percent of the total number of carcinomas of the breast are detected in routine examinations in patients who are seen for some unrelated complaint. The diagnosis of carcinoma of the breast requires no special technique or unusual instruments, but only a close relationship between the physician and the patient. The diagnosis of such lesions in the stage when the neoplastic process is confined to the mammary gland has such a direct bearing upon the number of five year cures that it is obvious that radical surgery and recent advances in radiation do not approach the practical value of early diagnosis.

Every woman who has an evident tumor of the breast, retraction signs or erosion of the nipple should be hospitalized immediately to have the nature of her lesion proved by biopsy. One should not be tempted to biopsy any tumor of the breast as an office procedure.

TREATMENT

The surgeon has little that is new to offer beyond the radical operation for carcinoma of the breast as described by Halstead in 1894. Though improvements in technique and surgical care may add to the patient's comfort, very little improvement in the clinical results has occurred since the time of Halstead and Willy Meyer.

The radiologist has extended himself in trying to justify deep therapy in the treatment of cancer of the breast. During one period preoperative radiation was thought to be of definite value, only to be discarded in most clinics at a later date. Likewise there was a period in which postoperative radiation was used in all cases. Subsequently this was changed in many clinics and only those cases showing glandular metastases were subjected to this type of therapy. In the absence of one form of therapy that is curative in all cases, our present energy should be directed toward early diagnosis and the use of a method of therapy that, when correctly carried out, attains the highest percentage of cures.

DIAGNOSIS

Early diagnosis continues to be of paramount importance when one realizes that if the tumor is detected while the disease is confined to the mammary gland it is possible to predict an instance of 70 to 90 percent five year survivals. On the other hand, if there is microscopic or gross evidence of extension to the axilla, the percentage of five year cures abruptly drops to an

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average of 20 to 25 percent. Though it is not possible to go into the details of diagnosis and differential diagnosis of breast cancer, certain well established facts should be repeatedly emphasized.

(1) In no instance should any type of discrete mass in the breast be "watched." The policy should be "look and see," and not "wait and see." If there is a discrete mass, observation is neglect. Any mass in the breast is abnormal, and if the woman is in the menopausal age and beyond it is even of more significance. (2) Ulceration, peau d'orange skin, elevation or retraction of the nipple and axillary node involvement are signs of advanced carcinoma of the breast and it is negligent to await their appearance. (3) Bloody discharge from the nipple indicates the presence of carcinoma until proven otherwise. About 50 percent of papillary cystadenoma and intraductal papilloma become malignant. (4) Erosion of the surface of the nipple is an important sign of carcinoma. The percentage of nipple erosions that are carcinomatous is so high that biopsy of the lesion and microscopic proof of its nature is always desirable. (5) Three lesions, fibrocystic disease, fibroadenoma and cysts, along with carcinoma, comprise the diagnosis in 90 percent of cases. (6) It should be emphasized that fibrocystic disease, when localized, is the most difficult to differentiate, and is the one in which carcinoma is the most likely one to occur of the three types of lesions mentioned. (7) Axillary lymph nodes are not palpable in 30 to 40 percent of cases when involved. If one takes a hundred cases in which a good surgeon states, after the examination, that the axillary nodes are positive, and then studies the pathological findings following radical mastectomy, one will find, nine times out of ten, that he is right. However, if one takes his estimation when he says the nodes are not palpable, or not involved, he will be wrong in 30 to 40 percent of the cases. These facts are extremely interesting to anyone considering the subject of simple mastectomy versus radical mastectomy based in part on the preoperative physical findings.

The treatment of carcinoma of the breast has been a subject of careful study since Halstead and Willy Meyer independently described the radical operation in 1894. Nevertheless, after over five decades of study and controversy there is still considerable confusion as to whether surgery alone or a combination of surgery and roentgen therapy will prove more beneficial. Trimble,⁴ in a paper published in 1940, quotes from personal communication from the heads of nine important surgical clinics in this country to emphasize that there is no unanimity of opinion on the most effective plan of therapy.

In spite of the lack of a universally accepted plan of treatment, it seems that one may state that radical mastectomy properly performed, alone or combined with postoperative roentgen therapy,

is the method of treatment that offers the best opportunity for cure.

In the face of the proven facts that from 20 to 30 percent of patients who exhibit axillary metastases are cured by radical mastectomy, the performance of a simple mastectomy in a patient who is considered operable and who can tolerate the radical operation is nothing less than surgical timidity. Time does not permit a detailed discussion of the criteria for selecting the operable cases. Haagenson and Stout have recently dealt in some detail with the question of operability.³ It should be emphasized that radical surgery should not be attempted in inoperable cases, as study has indicated that little can be accomplished. It is in such cases that radiation therapy has its greatest use as a palliative measure.

Careful selection of cases for radical mastectomy is an indication of the surgeon's knowledge of the disease and not an indication of timidity. One should always search for distant metastases in the preoperative period through emphasis on inquiry regarding skeletal pain and cough; careful examination of the supraclavicular region, other breast and liver; and roentgenograms of the thorax and other portions of the skeletal system as indicated.

CLASSICAL OPERATION

The history of the development of the operation of radical mastectomy has been well described by Cooper.⁵ Both Halstead⁶ and Willy Meyer⁷ made changes in their operative technique as time progressed and the operation evolved in their hands, until both operators emphasized four common principles:⁸ (1) Excision of the skin over the whole breast, covering the defect which remains with a Thiersch graft. (2) Excision of both pectoral muscles. (3) Complete axillary dissection. (4) Removal of the excised tissue in one block.

During the last fifty years there have been many variations in the technique of radical mastectomy. Emphasis has been placed by many on different skin incisions. Those who have been under the influence of the Halstead school of surgery have continued to elect to excise wide margins of skin about the mammary tumor and expect to close the defect with a split thickness graft in the great majority of instances. Others feel that wide excision of the skin is not an important factor in the prevention of skin recurrences or the ultimate course of the disease. These operators routinely limit their excision of skin so that primary closure may be accomplished. There is statistical data that would indicate that wide excision of skin does decrease the incidence of skin recurrence and that arm function following excision of large areas of skin has not been affected to a greater extent than with primary closure.⁹

The surgeon who plans to perform the Hal-

stead operation must be willing to spend adequate time to complete the radical dissection and when this procedure is completed, in sixty to one hundred and twenty minutes, it is doubtful if the procedure evolved by Halstead has been performed. The use of the silk technique adds to the ease of careful hemostasis and the exactness of the dissection. One who performs a radical mastectomy must be absolutely sure of his diagnosis so that such lesions as traumatic fat necrosis, low grade inflammatory disease and others will not be subjected to a formidable, mutilating operation.

Through the use of incisional biopsy and frozen sections mistakes in diagnosis need not occur. This procedure is necessary if radical mastectomy is never to be performed needlessly. It is doubtful if the treatment of tumors of the breast should be attempted unless this method of correct diagnosis is available. In some instances the surgeon, by virtue of adequate training in surgical pathology, is equipped to interpret frozen sections, should a skilled pathologist not be available in the community.

RADIATION TREATMENT

The value of radiation as an adjunct to radical mastectomy in the treatment of carcinoma of the breast continues to initiate much controversy. There are three schools of thought regarding its use: (1) those who do not advise it at all, (2) those who advise radiation only when there is evidence of axillary involvement, (3) and those who use it routinely in all cases. The statistical reports presented in support of each of these three programs are not conclusive. At the present time it is probable that the greatest number of patients with carcinoma of the breast are treated by radical mastectomy followed by postoperative radiation. It is almost universally agreed that radiation as the sole curative measure has no place in the treatment of a carcinoma of the breast that is considered operable by the usual criteria of operability. As a palliative procedure, radiation finds its greatest usefulness in the control of pain incident to bone metastases. The control of this symptom is of great importance in the terminal care of these patients.

INFLUENCE OF HORMONES

Hormonal alteration of advanced carcinoma of the breast has been of particular interest in the last few years. Huggins' study of the hormonal influence on the clinical course of carcinoma of the prostate naturally resulted in exploration of other fields where cancer is materially influenced by hormones. Previous studies had indicated the beneficial effects on advanced carcinoma of the breast following castration. Various studies indicated that 15 to 30 percent of premenopausal women with advanced, recurrent or metastatic breast cancer, may derive benefit from castra-

tion.¹⁰ However, the procedure does not appear advantageous when employed as a prophylactic measure as an adjunct to radical mastectomy in women whose disease is confined to the breast and regional nodes. At the present time it is believed by most observers that castration should be reserved for premenopausal patients with advanced, recurrent or distant metastatic breast cancer.

During the last several years much investigative work has been done to explore the possibilities and limitations of the use of sex hormones in cancer of the breast.¹¹ It has now been clearly shown that androgen therapy, in adequate doses, has an obvious effect on osseous metastases. After approximately two weeks of testosterone therapy the relief of pain from bone metastases in about one-third of the cases is very dramatic. However, radiation therapy will produce comparable results in cases where the lesions are sufficiently localized to make radiation practicable. Experience to date has indicated that testosterone therapy, when the breast cancer involves the soft tissues, is rarely beneficial. Adair has found that large doses of androgens are necessary to produce striking clinical improvement. At the present time the suggested dose is 100 milligrams by intramuscular injection three times weekly for a period of eight to ten weeks. It is well to remember that the administration of androgens usually causes masculinizing sequelae that may be the source of great annoyance.

Estrogens have also been employed in patients with advanced cancer of the breast. The improvement from this form of therapy is primarily limited to the soft tissue metastases and the improvement is confined to patients over sixty years of age. Favorable influence in bony metastases with estrogen therapy is relatively uncommon.

It should be clearly pointed out that hormonal therapy is not a cure for carcinoma of the breast and at the present time its use is only an adjunct to other palliative therapy. Unfortunately, the patients who have an initial favorable response eventually have a recrudescence of the disease process in periods ranging from a few months to a few years.

CONCLUSION

In conclusion, one can state that at the present time there are probably only two major factors that contribute to the survival rate of patients with malignant disease of the breast. The first factor is early diagnosis. Earlier diagnosis cannot be expected until a greater number of women with apparent abnormalities of the breast can be induced to submit immediately to competent medical examination. Pessimism regarding successful treatment on the part of the medical profession is not an inducement for women to present themselves for examination, but rather a deterrent.

This may be one reason to explain why some intelligent and well informed women with a lump in the breast wait ten months to a year before finally seeking medical advice. The survival rate of cancer confined to the mammary gland compares favorably with the survival rate of malignancy in other sites and this fact should be emphasized by all physicians.

The second factor that will contribute toward lowering of the mortality rate of cancer of the breast is the correct utilization of the operation of radical mastectomy. Since it has been conclusively demonstrated that this procedure is the best known treatment for cancer of the breast, those who do not carry it out thoroughly and diligently are not utilizing the most adequate method of treatment. It is within the realm of possibility that some of the pessimism regarding carcinoma of the breast would be diminished if this method of treatment were better understood and more thoroughly applied by every surgeon charged with responsibility of managing this disease. It is doubtful, however, if this desirable end can be accomplished

until there is a more general appreciation that inadequate mastectomies and ill-advised radiation therapy are not just as efficacious as radical surgery in the treatment of this disease.

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LESIONS OF THE COLON*

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KNOXVILLE, TENNESSEE

THE broad subject of lesions of the colon has been selected in this study because of the growing tendency among patients and physicians alike to regard too many colon aberrations as malignant. In arriving at a correct diagnosis and therefore a rational pattern of procedure in management, benign lesions must be eliminated first, paying due deference to the interrelationship factor between benign and malignant lesions of the colon.

ANATOMY AND FUNCTION

To the surgeon the colon is a most stimulating organ. It is different histologically inasmuch as its right half arises from the midgut, while the left half arises from the hindgut. Its blood supply is different inasmuch as the right half is supplied by the superior mesentery artery and the left half from the inferior mesentery artery.

The innervation is also different. The right half and small intestine, which it somewhat simulates in function, pass through the lumbar nerves and splanchnics to the superior mesenteric gang-

lion and proximal to the superior mesenteric blood vessel. The left half is supplied from fibers which leave the spinal cord, probably between the second and fifth lumbar nerves, and pass to the sympathetic chain and thence to the inferior mesenteric ganglia in proximity to the vascular distribution of the inferior mesentery artery and veins.

The right half of the colon is larger in size, has thinner walls and continues the absorption of fluids and terminal digestive processes for a short period of time after the thin food current, with its enzymes and digestive ferments, have passed from the ileum through the ileocecal valve to the cecum and ascending colon.

The left half of the colon is smaller in size, has thicker walls and, having lost its fluid content by absorption, contains only feces and serves as a storage reservoir.

The right half is restricted in mobility by less redundant peritoneal fixation while the transverse and sigmoid are freely mobilized and pendulous.

In function the right half may permit absorption of noxious and necrotic material with or without infection which produces marked anemia, weakness, pallor and cachexia with early symp-

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tomatology. The left half is slow to absorb, may become partially or completely obstructed due to annular contraction, may have constipation with alternating diarrhea, blood and mucus.

PATHOLOGY—CARCINOMA

The distribution of carcinomas in the right half of the colon is as follows:

- | | |
|---------------------|--------|
| 1. Ileocecal valve | 0.34%, |
| 2. Cecum | 6.5 %, |
| 3. Ascending colon | 3.3 %, |
| 4. Hepatic flexure | 3.0 %, |
| 5. Transverse colon | 4.5 %, |

while in the left half, the incidence becomes much greater:

- | | |
|---------------------|--------|
| 1. Splenic flexure | 2.4%, |
| 2. Descending colon | 4.0%, |
| 3. Sigmoid | 12.5%, |
| 4. Rectum | 53.3%, |
| 5. Anus | 0.5%. |

This incidence of location resulted from the study by Boehme of the Lahey Clinic in 1,457 malignancies of the colon.

POLYPOSIS

Among the primordial benign lesions of the colon are polyps. They are defined ordinarily as pedunculated masses growing from the mucosa of the intestine. They are of two varieties:

1. Adenoma,
2. Lipoma.

The average number of polyps seen in one colon is two. One may be adenoma; the other, a yellowish cast lipoma. Polyps are found in 5 to 15 percent of all people over 40 years of age. There are found, rarely however, the leiomyoma, fibroma, neurofibroma and hemangioma. Polyps are seen in children in probably 1 percent of cases, and over all the years the percentage may reach 20 percent or above.

Buie reported a series of cases in which proctoscopy and sigmoidoscopy were done which showed polyps present in one out of thirty-five patients.

Lawrence of Cook County Hospital studied 7,000 autopsies and found an incidence of 3.37 percent of polyps in the rectum varying in size from $\frac{1}{4}$ to 3 or 4 centimeters.

Charles H. Brown, formerly of Henry Ford Hospital and now with the Cleveland Clinic, reports an incidence of 2.3 percent rectal polyps in routine proctological examinations of 235 cases. His analysis of the symptom complex of his group showed:

1. Irritable colon in 132 cases.
2. Constipation in 76 cases.
3. Rectal bleeding in 21 cases.
4. Diarrhea in 17 cases.
5. Rectal discomfort in 9 cases.

Eighty-seven and one-half percent, or 205 patients, did not complain of any symptoms related

to the polyps. This is significant since it shows negative subjective symptoms but positive existing pathology.

Brown further states that of 186 of his series examined for occult blood, only 62 were found positive. His pathological studies showed biopsies taken in 175 cases with 123 cases benign, 36 questionable and 16 frankly malignant but of low grade. This corresponds to the data by both Buie and Swinton.

Pedunculated or sessile base, solitary or multiple, these polyps are situated predominantly above the last four to six inches of the gastro-intestinal tract.

Brown again studied the polyps from the standpoint of malignancy and found the incidence of 5.9 percent on first examination, which corresponds to that of Lawrence in his extensive autopsy studies, which showed 6.5 percent incidence of malignancy. Brown finally concludes:

1. That benign polyps of the colon are 17 times as many in number as malignant types; that 50 percent of polyps eventually become malignant.
2. That malignant rectal polyps are potentially malignant from the first or become so very early.
3. Twelve percent of patients gave symptoms which might be referable to rectal polyps.
4. Size of the growth has no relation to benignancy or malignancy.
5. That every complete physical examination should include a sigmoidoscopic examination.
6. That double contrast enemas should be used for x-ray diagnosis in lesions above 20 centimeters where the sigmoidoscope becomes of little value.
7. Polyps should all be removed intact, if possible, for pathological clearance. Hemorrhage, if of any consequence, may be controlled with fulguration.

We are using the above procedure in our Clinic in all new admissions, regardless of whether the leading symptom is gastro-intestinal or not.

DIVERTICULAE OF THE COLON

The incidence of diverticulae is greatest in the sigmoid, and rare in the cecum and rectum. The site of election perhaps is between the mesocolic and antimesenteric taenias. They are seen as bluish-black masses covered with fat, varying in size from 5 to 10 millimeters, and may contain solid masses of fecal matter. The structure or sac is thin since it usually contains mucosa, submucosa and serosa, the muscular coat being absent. Diverticulae are seen predominantly in obese people who are habitually constipated, and who are 40 years of age or above.

Fatty tissue weakens the structure of the colon by separating the muscle fibers and thus

causing intraluminal pressure by constipation which causes the sacculated diverticulum. The diagnosis is made by contrast barium and air enemas in 6 to 10 percent of patients.

Probably 50 percent of patients having diverticulae in appreciable numbers or of other than minute sizes will present one or more of the classical symptoms of diarrhea, epigastric distress, pain and tenderness with rigidity in the left inguinal region—the so-called left-sided appendicitis. If infection occurs in a given sac offside the bowel, continuous and adequate elimination is blocked, the diverticulitis might assume proportions of a highly acute process and require immediate exploration.

CHRONIC ULCERATIVE COLITIS

There is another lesion of the colon which may be benign at first and, because of long continued irritation, with the presence of polyps, might well become evolutionary to a malignancy of the colon. I refer to chronic ulcerative colitis.

These lesions are predominant in the rectum but may involve the entire colon and extend into the ileum and even into the jejunum. The wall of the bowel becomes thick, the lumen narrow, the color pale. The mucosa is rapidly destroyed, the ulceration invades and destroys the muscular coat, and at operation one may see numerous bulging sacculations being restrained only by a thin layer of serosa. These have ruptured, with resulting peritonitis and death. However, a compensatory fibrosis helps to hold the serosa by thickening the overlying crater.

The condition is too often diagnosed as and treated for chronic bacillary or amebic dysentery.

The complications are perforation with peritonitis, shock, perirectal abscess, fistulae, pyelitis, multiple liver abscesses and carcinoma of the colon, in about 5 percent of the cases.

The causative factors are not orthodox but are given as

1. Bacterial, as *bacillus dysenteriae*, *diplostreptococcus* of Bargen, *bacillus bacteroides* of Dack,
2. Neurogenic.

I recall a draftee who entered the service in the Pacific Theatre. After three months he developed diarrhea with mucus, blood and marked tenesmus. He lost appetite. His blood and weight loss were progressively downward. He was suspected of being one of the oriental dysentery victims and was sent to the base hospital for diagnosis and treatment. No specific organism could be found. X-rays were negative, all treatment was of no avail. The boy was finally discharged, apparently as an incurable.

After returning home, his outlook was more hopeful, he was mentally happy, but physically a defeated casualty. His diarrhea persisted. All of our staff, with outside consultation, studied

his case with the reluctant conclusion that he should have a colectomy. He was therefore transfused repeatedly and surgery was done. The entire colon from the cecum to the rectum was small, rope-like and pale—and devoid of haustrations. The liver was enlarged but smooth, the spleen and kidneys showed smooth enlargement.

The transfusion was continuous throughout the operation and colectomy was performed with the ileum sutured end-to-side to the lower end of the rectosigmoid. The patient withstood the procedure in good condition, some diarrhea persisted for awhile, there was gain in weight, and optimism for return to health prevailed and he made an uneventful recovery. The pathological report showed only marked destruction of mucosa and muscularis with fibrosis, but no malignant changes and no constant micro-organism.

In retrospect we are all convinced this was a case of chronic ulcerative colitis with a neurogenic etiology. There are more of such cases than we are cognizant of.

3. Allergic theory is the one which is truly cryptogenic. The whole field of allergy is floundering in the realm of polemics with its many intangibles, and yet it is rewarded many times with the most dramatic and ingratiating cures of our art.
4. Deficiencies. Among these are the vitamin and nitrogen deficiencies. Whether these are causes or effects of the disease has not been proven. They are, however, seen in varying degrees of intensity as the disease progresses.

Thorough diagnosis, ample trial with medication, antibiotics and specific therapy, if determined and not too dangerously late, should be tried, and if there is no improvement, then a turn to surgery to whatever degree may be suggested by capable and experienced surgeons.

DIAGNOSIS

What shall we say to the patient who comes with only a mild pruritis of the anus, a few visible external hemorrhoids, or a sense of discomfort in the rectum? Unfortunately there are no symptoms which are pathognomonic of malignancy of the colon and rectum. A careful history by a good symptom analyst will give much valuable information. Any patient who trusts his or her life in the hands of any doctor deserves a careful and painstaking examination.

I sincerely trust the day has gone when even the least of our great profession would give such a patient a "brushoff" with ill-timed and pseudo-verbosity. The terrorizing finger of guilt should follow such a physician, like the shadow, until his bed would become one of anguish and his conscience would direct the pangs of impending chaos and death into his own guilty being, until the last drop of charlatanism had vanished

from his body. Here if never again should we practice the Golden Rule, because who knows when one of us will be pleading for help with a similar condition. We never get beyond the Cancer Age—and there is no truce with its deadly march of destruction. Surely the preceding paragraph should augur for a thorough rectal examination.

The examining finger is by and large the greatest diagnostic agent we have—first because it is always present; second, because 54 percent of polyps and malignant lesions can be felt by digital examination.

Supplementing this examination with the short or ten inch sigmoidoscope, one brings into view the remaining 10 percent of lesions in the recto-sigmoid and 12 percent in the sigmoid, plus the 54 percent in the rectum proper, where observation and evaluation can be made. More than 70 percent of the lesions of the colon can then be studied and sectioned for biopsy purpose and the malignant or benign status determined.

A very large clinic in our country makes this very significant statement; that cancer of the rectum and sigmoid can be made resectable in 85 percent of cases by improved diagnosis, pre-operative preparation, better anesthesia, better trained and experienced surgeons, the use of blood, plasma, proteins and chemotherapy. These factors, supplemented with good postoperative care and follow-up status, have given a five year survival rate of 50 percent. This is truly a challenge for other clinics and surgeons to emulate.

It may sound prosaic, but I am of the definite opinion that early diagnosis of rectal cancer took a step backward with the discovery of the x-ray. This statement is based upon the indiscriminate and wholesale use of x-ray, with its convincing salesmanship to an unsuspecting and gullible public, which still looks upon the x-ray as the finality in diagnosis. For time-saving as well as for mercenary reasons, too often the patient is referred to x-ray for a barium enema which in reality overshadows the lesion which could be found with the finger or the sigmoidoscope. I maintain the highest respect for the radiologist who not only knows colon interpretation, but who will take the time to do the necessary barium contrasted with air enemas, and who will repeat such an examination if his diagnosis does not conform to the clinical picture. Here again the commercial x-ray too often is "grinding" out films and reports, when it is actually and seriously a consultation which is desired.

A thoroughly trained and conscientious radiologist must work closely with the gastro-enterologist and the surgeon as a team, if early diagnoses are to be made, resectability rates increased and mortality levels lowered.

CARCINOMA OF THE COLON AND RECTUM

These two considered together rank next to the stomach in incidence and death rate of can-

cer in the gastro-intestinal tract. Eighty-five percent of these are seen in people above 40 years of age. Fifty percent of carcinomas of the alimentary tract are found in the rectum, 25 percent in the sigmoid and 25 percent in various sections of the remaining colon. Grossly there are two main types:

1. Annular and constricting. This type grows around the bowel, thickens and constricts its lumen, often ulcerates and may lead to obstruction. It may well start from malignant change in a small polyp.
2. Papillary. Here the growth appears as a bulky mass projecting into the lumen of the bowel to the point of obstruction.

Ninety percent of carcinomas of the colon and rectum are of the adeno type, since they show tendency to gland formation.

It is desirable to know the degree of malignancy from the standpoint of treatment as well as prognosis. Broders has given to the profession a histologic method of grading based on the degree of invasiveness, glandular arrangement, nuclear polarity and frequency of mitosis. These factors indicate the rate of growth from grades I, II, III, IV.

Dukes' classification is based upon the degree of spread as

- Group A: Cancer has not spread through the rectal wall.
- Group B: Cancer has penetrated the rectal wall but has not invaded the adjacent lymphatics.
- Group C: Cancer is diffuse and has invaded the local lymphatics.

Clinically this classification works well during an operation since Group A would very nearly approach Broders' Grades I and II. Group B is similar to Broders' III. Group C is similar to Broders' III and IV.

METASTASIS

The spread of carcinoma of the colon and rectum is by an orderly, insinuating, persistent, progressive node to node upward along the iliacs and the aorta. It may even travel by the thoracic duct to the supraclavicular nodes. It is safe to assume that identity of any remote node enlargement means that all intervening glands are involved with their adjacent and visceral organs.

Spread of the disease through the venous system results in implantations into the liver, lungs, bones, suprarenal glands. It is all too true that with vascular system invasion, plus lymph node invasion, the prognosis is exceedingly poor and the termination fatal and rapid. Lahey Clinic records only 14 percent five year survivals when the veins and glands were both involved, 37 percent if only lymph nodes, and 90 percent if neither

were invaded and the lesion was still confined to the bowel.

TREATMENT

Under the management of carcinoma of the colon and rectum, there are four procedures to be considered. The surgeon who attempts colon surgery should be familiar with all of them. I refer to the long accepted abdominoperineal resection of Miles in one stage and two stages, the anterior resection, and to the proctosigmoidectomy with preservation of the sphincter in the last two.

When the diagnosis, location and stage of the disease have been determined, the operative risk must be considered as to his ability to withstand the procedure. In preoperative management one can safely assume that these patients have had the disease for an average of nine to twelve months, that they are anemic, dehydrated and are deficient in body vitamins. The preparation of the patient should require four to seven days in the hospital, receiving low residue foods but high in protein and carbohydrate, amino acids, parenterally, 50-100 gm. daily, if appetite is poor. Vitamin therapy parenterally daily, including ascorbic acid 300 mgm., Thiamine Hydrochloride 50 mgm., Riboflavin 3 mgm., and niacin 150 mgm., should also be given.

For anemia and hypoproteinemia, nothing will supplant whole blood. This is given prior to and during the operation in 500 cc. amounts, until the patient's condition is well fortified for the ordeal. One of the sulfa drugs is given freely for four days. Blood is used generously in amounts from 500 cc. to 5,000 cc. or more. The cleansing enema is used daily for two days prior to operation. Spinal anesthesia is preferred, as well as a well trained surgical team.

If the lesion is located in the anus, rectum or rectosigmoid, I prefer the combined abdominoperineal resection because of the opportunity it affords to resect well above and below the tumor. The lateral spread of cancer along the lymphatics between the levator planes is well known, and it is through this spread that recurrence is frequent. Excision of the sigmoid high above the lesion with separate colostomy, and in the perineal phase going wide to include all of the levators and the ischiorectal fat, gives the best possible chance of cure.

If the lesion is not still confined to the bowel but has invaded the surrounding lymphatics, bladder, prostate, uterus and ovaries, with metastatic nodules in the liver, I feel that this case is inoperable and colostomy only is justified.

If the lesion is situated as much as three inches above the peritoneal covering of the rectum, I use and prefer the anterior resection with primary anastomosis and preservation of the sphincter. This is one of the relatively new procedures, is

not easy, especially in large or obese patients, but an increasing percentage of three to five year survivals lends encouragement to us as surgeons to make the operation and cure, if possible, the least objectionable to the patient.

The exteriorization operation in multiple procedures, the two stage method of Lahey, Rankin and many others, seems to be the safest in advanced cancer in the hands of the surgeon who operates only occasionally on colon cancer.

Bacon and Babcock of Philadelphia have done some excellent work in removing the lesion and preserving the sphincter. They have shown (Bacon) in a series of 76 cases that the five year survival rate has been 52.6 percent, with a recurrence rate of 34 percent.

These figures compare favorably with the overall statistics and give the added comfort and desirable preservation of bowel continuity and the use of the sphincter. I am fully aware of the controversial aspect of this latter operation of both anterior resection and proctosigmoidectomy, but surgery must make progress and surgeons must not be too quick to condemn a procedure which has many desirable features if only the undesirable ones may be kept at even a comparable level with conventional procedures. These procedures have inaugurated the only radical departure in colon surgery since Miles devised the combined abdominoperineal operation in 1914.

In other lesions of the colon which exist in the mobile sigmoid, descending, transverse and ascending colon, segmental resection and end-to-end anastomosis is decidedly the procedure of choice. In lesions of the right half of the colon involving the cecum, with or without obstruction, the physical condition of the patient should be brought up to par, the colon thoroughly sterilized so far as possible, and resection done of the entire head of the cecum, ascending colon, hepatic flexure with end-to-side anastomosis from the ileum to the transverse colon.

I have recently had a patient who became completely obstructed in the splenic flexure of the colon with practically no premonitory symptoms. At the operation an annular obstructing lesion was found near the splenic flexure, causing complete obstruction. The splenic flexure was liberated, allowed to drop down, and a segmental resection of the lesion, going well above and below, was done, and end-to-end anastomosis. The patient made an uneventful recovery, and although a marked short-circuiting at the splenic flexure was effected, it apparently is compensated for satisfactorily. The relief afforded in early right colon surgery, as well as other neoplasms in other segments of the colon, is most gratifying.

While much progress has been made in treatment of the acid-bearing portions of the gastrointestinal tract, the survival statistics of the colon are much more gratifying than those of the stomach. Papanicolaou has advanced the theory of

recognizing cancer cells from rectal and gastric washings. It offers hope because if only one genuine cancer cell is found, it is proof positive that cancer exists somewhere in the area being examined and directs attention to a more thorough and corroborative examination.

As physicians and surgeons, we are today at the crossroads of our battle against cancer, a generous public is giving \$12,000,000 annually to aid us, cancer has been known as a disease entity perhaps as long as any within our knowledge, and while we know some 284 agents which will produce cancer, and while the archives of the American College of Surgeons contain some 40,000 cases which have been cured for five years or more, we wonder whether or not these cases do

not come largely from the ranks of those seen and treated early. Early recognition and early adequate treatment by surgery is our slogan. Is that all we can say?

Science in every phase of our economy has led the way. Is science, in cancer control, keeping pace with the progress in comparable endeavors?

One hundred fifty million American citizens of our United States are pleading with an army of 200,000 physicians to seek out, identify and destroy the second greatest killer of mankind. The toll of cancer each year is the same number of people as the number of doctors who fight it. As men of science we must strive to learn the answer. We must assume our responsibility. We must meet the challenge.



RADIOISOTOPES AVAILABLE FOR CANCER RESEARCH WITHOUT CHARGE

The U. S. Atomic Energy Commission announced on February 27 that it will make available to qualified cancer research workers in the United States without charge all radioisotopes now being sold.

Dr. Shields Warren, Director of the Commission's Division of Biology and Medicine, said the action will result in a significant enlargement of the Commission's four-point cancer program. This program, announced in March, 1948, has as its basic objective the development of the use of radioactive substances in studies of the nature of cancer, its diagnosis and treatment.

Under the program, three radioisotopes—those of the elements iodine, phosphorus and sodium—were previously available free of production costs for use in cancer research.

The new policy will make available on a free basis the radioisotopes of more than 50 additional elements. Notable among these is the radioisotope of the element cobalt—known as Cobalt-60—which promises to become an effective substitute for

radium, the rare and expensive naturally-radioactive substance that has been used in cancer research and treatment for many years. Two other important cancer research materials that will now be available without charge are the radioisotopes of the elements gold and carbon.

The new program has been made possible through the improvement of isotope production techniques at the Oak Ridge National Laboratory, Oak Ridge, Tennessee, and at the Argonne National Laboratory, Chicago, Illinois. The great majority of Commission-produced radioisotopes, useful in industry and agriculture as well as biology and medicine, are made in the nuclear chain-reacting pile, or "atomic furnace" at Oak Ridge.

The distribution of isotopes is administered by the Isotopes Division, U. S. Atomic Energy Commission, Oak Ridge, Tennessee. Inquiries from interested investigators should be addressed there. It is expected that most applications for use in human subjects will arise from institutions having a definite research program in this field.

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

A.M.A. 12-POINT HEALTH PROGRAM

THE Board of Trustees of the American Medical Association, in announcing the 12-point health program, has crystallized in outline form the principal objectives of American medicine. Many of these objectives have been stressed and advocated by the A.M.A. for several years. Their restatement and grouping at the present time is helping to point up the "positive approach" which is being adopted for the campaign against compulsory health insurance.

The program is described by *The Journal of the American Medical Association* as "far more comprehensive than any yet proposed by either the President of the United States or the Federal Security Administrator."

The Journal also states that "It has the advantage that it can be developed and administered as a logical evolution from the existing institutions in the United States without bringing about chaos through a complete overthrow of what has already been admitted by everyone to be the highest quality of medical care available in any country in the world."

The program has the further advantage of being made up of points which have been championed by the A.M.A. on previous occasions. Some of

the proposals antedate all the government sponsored plans for compulsory insurance and socialized medicine.

Enough of the A.M.A. program has failed of adoption by responsible agencies in years past to raise the question as to whether acceptance of the A.M.A. recommendations, as and when made, might not by now have corrected the deficiencies which the A.M.A. and the government are trying to alleviate.

A Federal Department of Health, with cabinet status, to coordinate all national health activities, was first recommended over 75 years ago. The recent Hoover Report indicates how essential such a step is and has been.

The 12-point program also has the advantage of advocating the extension of public medical care in the fields of public health, mental hygiene, health education, and care of the medically indigent. These are fields in which public endeavor has demonstrated itself to be most efficient. The program leaves the ordinary medical care of the great bulk of our population to free and unfettered private medical practice, which for this purpose surpasses any other type of medical care which has ever been devised.

WILL WE AWAKEN IN TIME?

MOST Americans are inclined to suspect military men of seeking too much power, too much control over the lives and liberties of the people. That fear of the military has been a traditional part of American character. But strangely enough, in the last two weeks, two of our greatest wartime generals gave evidence of a far better understanding of the way in which free people lose their liberties than most politicians have been showing lately.

General Dwight D. Eisenhower warned Americans of the ease with which dictatorship can fasten itself on a free people that refuse to take the trouble to see where they are headed. In a speech at the Columbia College Forum on February 13 he said, "There is a kind of dictatorship that can come about through a creeping paralysis of thought, readiness to accept paternalistic measures from the government, and, along with those paternalistic measures, coming a surrender of our own responsibilities . . . a surrender of control over our own lives and our own right to exercise our vote dictating the policies of this country.

"There'll be a swarming of bureaucrats over the land," said Eisenhower. "Ownership of property will gradually drift into the central government, and finally you have dictatorship."

This sounds more like the liberalism of Washington and Jefferson than the modern "liberalism" of our New Dealers. Today's "liberals" seek to impose strong Federal controls over our lives through the dispensation of "free" benefits paid for by heavy and insupportable taxes. A government can give the people nothing that it does not first take from them. And every time the government dispenses benefits it exacts a new measure of control over the lives and liberties of those who receive it.

General Omar Bradley said much the same thing in an article in *Colliers* last week. "Apart from its economic implications," said Bradley, "this habit of turning to Washington with our troubles conceals a political danger as well. For, once we make a crutch of government, we are on the way to becoming political cripples." Once the government controls the economic life of a nation it also controls its political life. Like children who depend on their parents, citizens of the welfare state are not only dependents, they are also controlled by the governmental Great White Father.

"Overdependency on government," said General Bradley, "is the road to enslavement." If the American people want to remain free they must accept the responsibilities of freedom. Like adults they must decide to solve their own problems and to make their own way. If they allow government to solve their problems, that way will be chosen for them.

People only surrender their liberties when they have been deluded. Today's delusion is security

through government, instead of security through our own efforts. Unless we Americans realize this soon, we will wake up to find ourselves already the prisoners of our selfish irresponsibility, and the last great citadel of human freedom will have been breached by dictatorship.—*The Indianapolis Star*, Feb. 20, 1949.

BRUCellosis

THE ULTIMATE control of brucellosis in human beings will depend upon the eradication of its counterpart in domestic animals. Brucellosis is beginning to be known as a rather common affliction. Due to its protean manifestations and prolonged course, it presents many difficulties in diagnosis, and it is very probable that the number of undiscovered and undiagnosed cases exceeds the number of reported cases. It has been estimated that between 30,000 and 40,000 persons are affected in the United States annually.

The Indiana State Board of Health, in cooperation with Purdue University, the Bureau of Animal Industry, and the Public Health Service, is now engaged in a survey of the brucellosis problem in representative areas of the rural population of Indiana. The objectives are primarily to ascertain the human and animal reactors in representative townships of the state in an effort to establish factual data on the incidence of the disease in humans and animals, to correlate the incidence in animals and associated infection in humans, and to study new diagnostic procedures.

The medical profession, naturally, is interested in all brucellosis research and control work in domestic animals, since elimination of the animal reservoir of the disease would also entirely eliminate the infection in the human. Accordingly, the project was approved by the Executive Committee of the Indiana State Medical Association before the initial survey was started.

In spite of the fact that pasteurization of milk is an effective measure as far as human brucellosis is concerned in urban population, there still remains a considerable number of users of raw milk who would be protected if dairy herds were free from infection. It would also eliminate infection among those groups who are in direct contact with the animals, such as farmers, veterinarians, and slaughter-house workers.

The economic advantage to the dairy industry of effective control of Bang's Disease would be tremendous. Action by the 1947 General Assembly in modifying the brucellosis control act makes it possible to control the animal infection on an area-wide basis.

Monroe County has the honor of being the first county in the state to take advantage of the new law; the county is now fully organized for its eradication campaign and has an appropriation of \$5,000 to finance the first year's work. Neigh-

boring counties of Owen, Lawrence and Sullivan are starting to organize for similar control work.

Progress elsewhere is indicated by a brucellosis publicity campaign which is being fostered jointly by the Ohio State Medical Association, the Ohio State Veterinary Medical Association, and the Ohio State Department of Agriculture.

Editorial Notes

At present, 55,000,000 Americans are protected against the costs of hospital care, and 37,000,000 employees and their dependents are providing in advance for surgical or medical bills.

The March 15 issue of *Look Magazine* contains an article which will be of double interest to Hoosier doctors. Entitled "What's Wrong With Doctors," it was written by Dr. Maynard Austin of Anderson, past-president of the Indiana State Medical Association.

Dr. Austin emphasizes the importance of personal interest and friendship in the relations of doctors with their patients, and discusses the means whereby the curricula of medical schools may be improved to teach more of this side of medicine to students.

The introductory paragraphs remind us of a pronouncement of one of our medical teachers, to the effect that "A doctor who makes friends of his patients need never worry about the financial rewards of his practice."

To acquaint a doctor as early as possible in his training with the importance of the personal and emotional factors in illness, Dr. Austin favors the system of outpatient house calls, in which the student visits the patients in their homes and cares for them under supervision.

This part of the article also reminds us of student days. It recalls valuable lessons learned on the outdoor obstetrical service as a junior and as a senior student. It recalls time spent as an intern on the hospital outdoor "puddle-jumper" service. It reminds us that as recollection has grown dim for the many lessons carefully taught us in didactic lectures, the precepts acquired in these outdoor services have been enhanced by the passage of time. Experiences and lessons of the outdoor services are easily remembered, because they are a part of everyday practice.

A.M.A. ASSESSMENT

News from Mr. Ray E. Smith, executive secretary of the I.S.M.A., who is acting as agent in the collection of the \$25.00 A.M.A. assessment, is most encouraging and indicates a widespread and enthusiastic response.

At the time this issue of *THE JOURNAL* goes to press a grand total of 1,815 members of the Indiana State Medical Association have already forwarded their contributions to the association headquarters.

The response to the call for financial aid for the educational campaign by the American Medical Association is indicated by the receipt of many of the assessments prior to the time that the official receipts were printed. Many of the honorary members of the association, although ordinarily exempt from the payment of dues, have contributed to the fund. This week the office received the payment from a member of the association whose practice is in Africa.

J. W. Goldsmith and J. L. McKelvey, of St. Paul and Minneapolis, have the following to say in *Minnesota Medicine* for February, 1949 on "Common Errors in Rh Testing":

Errors in Rh testing have led to many instances of severe transfusion reactions and even to fatalities. Equally as tragic is the sensitization of Rh-negative girls and women in the child-bearing age by transfusions because of erroneous classification with respect to the Rh factor.

It is of utmost importance that the proper type of antiserum be used for the particular method employed. When testing by the slide method of Diamond and Abelson, only antisera containing blocking (univalent) antibodies can be used and all crystalloids must be eliminated from the system. The vial of testing material should state: "For the Slide Test Technique." Any other sera should not be used for this test. For tube testing, antisera containing either blocking antibodies or agglutinins (bivalent) antibodies or both, may be used. Regardless of the method employed, the proper conditions of temperature and time must be observed for that particular method. For example, when performing Rh tests by the tube technique, the tubes must be incubated at 37° C. for one hour before they are read. Thereafter, they may be read with or without centrifugation.

A frequent source of error has been the antiserum itself. Testing sera of animal origin will react with the red blood cells of all newborn infants to give a positive test regardless of Rh status. Many such sera will also give results on other erythrocytes that cannot be constantly reproduced. Hence human, rather than animal sera should be used. Moreover, various lots of antisera even from the same source vary in speed of reaction, specificity and degree of agglutination produced. Much of this is determined by the antibody titer. Antisera with a low titer may fail to agglutinate cells containing agglutinogens which are "weak" or incomplete. Therefore, it is essential that each new lot of testing material be checked against known Rh-positive cells, preferably of several Rh types. The National Institute of Health has established a titer of 32 as a minimum acceptable standard.

President's Page

ARE THESE OUR CHILDREN?

SOMEONE recently said, "There are three sides to every question; our side, the other side, and 'to heck with it.'"

In the July, 1946, issue of our JOURNAL, Doctor Shanklin presented considerable editorial comment on an interesting and factual brochure of the Metropolitan Life Insurance Company entitled, "What Ails Our Volunteer Health Agencies?"

Exactly two years later our eminent past president, Dr. Cleon A. Nafe, devoted his entire President's Page to "**VOLUNTARY HEALTH AGENCIES.**" I ask you to stop here and read the reprint of that article on the opposite page.

(Read the next page now.)

Doctors Shanklin and Nafe are men with vision, but they are not visionary. They had the courage and foresight to warn us of the trends in voluntary health agencies. Surely it is our duty to carry on from here.

Most of the 20,000 volunteer health agencies referred to by Doctor Nafe are direct or indirect inspirations of scientific American Medicine. They are our children and our responsibility. Each one is striving to solve some phase or problem of health. Nationally, they represent millions of sincere and intelligent people who should be marching as allied forces under the banner of the medical profession.

Unfortunately, many of these valuable agencies of health lack adequate medical guidance and are straying away from the ancestral homestead of American Medicine. Blinded by the brilliance of a political panacea, they are falling one by one into the crater of a socialistic health volcano. Little do they realize that all volunteer health agencies will be destroyed if American Medicine loses its freedom.

Doctor Nafe called your attention to the value of local health councils as the logical means of correlating the various health programs and determining the local health needs, but I find that many of the seventy or more organized local health councils in Indiana need more active participation by the local physicians and the county medical societies. In fact, there are a few county medical societies and many physicians who are taking the "to heck with it" side of the question and refuse to participate in the activities of their local health councils and other volunteer health agencies.

BROTHER, WHEN YOU DO THIS YOU ARE PROVIDING AN OPEN DOOR AND A FERTILE FIELD FOR THE DISCIPLES OF OSCAR EWING.

Believing that it is imperative that we do something to remedy this condition and make a statewide effort to mobilize all the worthy civic, volunteer, and professional agencies of health,

A NEW COMMITTEE WAS BORN.

Dr. F. R. Nicholas Carter is general chairman of this important new committee and at his side are more than twenty chairmen of important committees of our state association. It is a distinguished roster of leaders in Indiana Medicine, representing every section of our state. To these men I have assigned a great responsibility.

THE COMMITTEE ON CIVIC RELATIONSHIP AND COMMUNITY HEALTH AGENCIES

"A Committee to study and correlate the programs and services of the medical profession, the allied professional groups, the public health departments, and all the meritorious volunteer agencies of health; and to promote active local participation by the doctors and scientific counsel and guidance by our State Medical Association in a united program of health education, research, disease prevention, and adequate and economic medical care for all the people of Indiana."

It is a gigantic committee assignment, deserving the active cooperation of every physician in Indiana.

Regardless of what adverse action may be taken by Congress before or after this page comes off the press, the work of this committee must go on.

The answer to the problem of adequate medical care will never be in the ballot box or the result of compulsory legislation.

The answer will come when we bring our children back to the old homestead and mobilize under the banner of American Medicine the millions of sincere and intelligent people now enlisted in these volunteer agencies of health.

THEY ARE OUR CHILDREN

Augustus D. Hauss



President's Page



VOLUNTARY HEALTH AGENCIES

SINCE the beginning of this century the voluntary health movement has had its fullest flowering in the United States. A recent study, inaugurated by the National Health Council, reveals that they have grown from a mere handful to over 20,000 during this period. Nowhere else in the world has this type of service developed to such an extent or in such variety. Some of these agencies are national, while others are purely local in the scope of their activities. Scarcely any disease of the body or section of the country has been neglected, although their main activities are in congested areas. These agencies are highly specialized expressions of the human impulse to relieve suffering and afford an opportunity for the community expression of neighborliness.

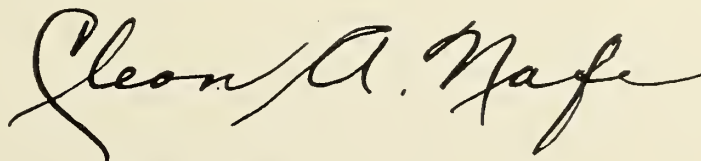
It is difficult to estimate the contributions that these voluntary health agencies have made to improvement in the health of our people, or to evaluate the influence they have been in creating the expansion of the activities of health services supported by taxation. Undoubtedly, they have contributed much. In general their activities have been beneficial. It has been the established policy of the state medical association and its members to cooperate with the agencies and wisely direct their activities, if they were in the interest of improvements in health.

However, as various private and tax-supported health facilities have been increased, the need for many of these voluntary agents has diminished, yet more such organizations are being formed each year and few of them disappear, because of the desire of the executives to maintain their jobs, and because many prominent people desire to retain the project in which they have a sincere interest and pride in its accomplishment. As a result, many of these groups strive to expand their activities into new fields in order that their continuation may be justified.

This has resulted in an overlapping of functions and duplication of effort of voluntary and tax-supported agencies, with considerable waste and extravagance. The public has become confused as to which of the projects are worth-while and the extent to which they should give their financial support. It seems essential that more effort should be expended to correlate the activities of all health agencies, both on the state and local level, so that inequalities and duplication would be lessened.

The A.M.A. and its rural health committees have suggested the creation of local health councils. Already seventy of these have been formed in Indiana. These are composed of physicians, representatives of allied professions and other interested prominent laymen. Physicians should advise these groups wisely, and may be of great service to their community in these projects. The health councils should study the health needs of the community, act as leaders in formulating plans to meet their needs and strive to eliminate wasteful duplication of health activities.

The health council might unite the fund-raising activities of these voluntary health agencies in each community, much as the Community Fund has correlated the activities of many social agencies, and set up a joint fund-raising program. Many of these voluntary groups may object to such an arrangement, and it may have its disadvantages. On the other hand, the public is entitled to a better evaluation of its health needs and of the individual responsibilities of citizens to the many requests for contributions now being made. There are now many agencies overburdened with funds while others have insufficient funds to operate properly. It is my judgment that this is a project that needs careful exploration and that physicians should stimulate this activity by the health councils, or some similar local group.



Reprint of Dr. Nafe's President's Page, July, 1948.

INDIANA MEDICINE WEATHERS STORMY LEGISLATIVE SESSION

J. WILLIAM WRIGHT, M.D.,* AND DONALD E. WOOD, M.D.*

INDIANAPOLIS

HE medical profession was exposed to the constitutionally stipulated sixty-one day session of the Indiana General Assembly, plus two days (while the clocks were stopped), but we are happy to report medicine did not contract any "legislative disease." While several bills approved by the Indiana State Medical Association did not pass, on the other hand a number of bills opposed by the association did not pass, either.

Three bills introduced by the chiropractors were defeated. Two of the bills would have removed the injunction provision of the 1927 Medical Practice Act, making it virtually impossible to keep anyone from practicing the healing arts illegally in Indiana. After each arrest the violator could have resumed practice, and the long process of collecting evidence, trial, et cetera, would have been necessary, with the violator having nothing more to fear than a small fine. These two bills died in Senate committees.

The usual bill to create a chiropractic licensing board and take care of those now practicing chiropractic illegally in the state was introduced. The chiropractors worked harder than ever to get the bill through. The House Committee on State Medicine and Public Health held a public hearing, after which the bill was amended in committee to create a Chiropractic Study Commission to investigate chiropractic education in Indiana and to report at the 1951 session. Two chiropractors, one physician, one osteopath, and the dean of the graduate school of Indiana University would have been the personnel of the commission. The two authors of the bill, who were members of the committee, submitted a minority report calling for passage of the bill as originally introduced. The House accepted the study-commission-amended bill, 55 to 33. When the bill came up on second reading, one of the authors had it recommitted to Ways and Means B to kill it. It was very evident the chiropractors did not want an investigation of their three Indiana schools.

A bill to codify the health laws, which was drafted by a committee appointed by ex-Governor Gates, was fought bitterly by the chiropractors and other drugless practitioners. While the bill did not contain any provisions not already on the statute books, the drugless healers wrote various interpretations into the bill. Among their charges was that it would outlaw all forms of practice of healing in Indiana except medicine. Legislators were besieged with letters, telephone calls and

telegrams, as a result of the campaign against the bill. An Indianapolis radio broadcaster charged the bill was trickery and vehemently attacked the state medical association and the state board of health. The bill passed the Senate, 46 to 0, and the House, 64 to 21, much to the disappointment of the chiropractors.

A bill permitting use of state funds for local health units, sponsored by the Indiana Advisory Health Council and approved by the medical association, was defeated in the Senate, 30 to 10. Opposition to the bill developed because of the state's desperate revenue situation.

The lone bill introduced by the Indiana State Medical Association upon direction of the House of Delegates died in a House committee. This bill would have increased physicians' fees and mileage for insanity inquests. It was branded a "salary grab" bill, and while some bills to increase salaries and fees did pass, the committee refused to report this bill.

A bill providing institutional treatment for persons declared by a court to be chronic alcoholics, upon a physician's declaration, was vetoed by the Governor. The Governor said in his veto message that the purpose of the bill was laudable, but that Indiana had no public institutions in which to care for chronic alcoholics, and the constitutionality of the provision compelling a defendant to pay his expenses upon commitment to a private institution was questionable.

Of the 277 bills which became laws, following are those of apparent interest to physicians:

SENATE BILLS

S.B. 9 (Kendall-Sunderland)—Changes name of the Northern Indiana Hospital to the Dr. Norman M. Beatty Memorial Hospital.

S.B. 19 (Baran)—Enables two or more school corporations to unite to employ one school physician to serve the schools operating under the agreement; also authorizes agreements by which physicians may serve both as school physician and civil city health officer. Emergency.

S.B. 39 (Gardner - Eichhorn)—Codifies all health laws enacted since 1881. Emergency.

S.B. 50 (Baran-Gardner)—Abolishes present Indiana State Board of Examination and Registration of Nurses, and transfers its duties to the Indiana State Board of Nurses Registration and Nursing Education, which the bill creates. New board would comprise five members named by the Governor but present members of the old board will complete their terms on the new board. Provides for licensing of practical nurses. Reduces minimum age for registered nurses from 21 to 20 years. Requires practical nurses to have at least one year of accredited training. Emergency.

* Co-chairmen of Committee on Public Policy and Legislation.

S.B. 57 (Shake-Beaman)—Broadens the power of the board of managers of county tuberculosis hospitals.

S.B. 103 (Kendall)—Requires physicians to report to State Board of Health all cases of blindness or serious visual impairment, provides \$25 fine for failure to report such cases. Health Board will use reports in determining eligibility for rehabilitation or assistance.

S.B. 247 (Bontrager)—Authorizes a building or accumulating sinking fund for construction of hospitals or repairing and remodeling present hospitals owned by counties or voluntary nonprofit associations; also authorizes a tax levy to build up the funds.

S.B. 285 (Gardner)—Permits circuit and superior courts to commit senile persons to county infirmaries, and if their condition later warrants it, to commit them to mental hospitals without further hearings.

HOUSE BILLS

H.B. 2 (Slenker-Rogers)—Provides for commitment of sexual psychopathic persons to the Indiana Mental Health Council for treatment in state mental hospitals instead of sentencing to prison. Exempts persons accused of murder, manslaughter or rape of a child under 12 years old.

H.B. 55 (Klein)—Amends 1943 act to include State Board of Medical Registration and Examination among professional boards required to give servicemen renewal of licenses without prejudice due to military service. Emergency.

H.B. 72 (Griggs)—Creates the Indiana Tuberculosis Council of six members appointed by the Governor and the secretary of the State Board of Health, to integrate the state's tuberculosis program. Emergency.

H.B. 73 (Klein-Neumann)—Validates action of the Board of Medical Registration and Examination in waiving penalties and fees for servicemen.

H.B. 274 (Danielson)—Provides for financing of a hospital in German Township, Marshall County; authorizes tax levy to assist in maintenance and support of the hospital; sets out means of payment of mortgage indebtedness and provides for additions to the hospital. Emergency.

H.B. 290 (Combs)—Amends workmen's compensation laws to require employers or physicians to provide employes with results of physical examinations prior to hearings on compensation cases. Also restrains employer from causing employe to submit to a physical examination less than 10 days before a hearing.

H.B. 311 (Combs)—Amends occupational disease act to require employer to provide employe with copies of physical examination report within seven days after examination or 10 days before hearing, whichever is sooner; provides employer shall have no right to require employe to submit to an additional examination less than 10 days before hearing of case.

H.B. 412 (Brennan-Steele)—Permits acceptance of "pay" as well as charity cases at the Northern Indiana Hospital for Crippled Children.

GRANGE ENDORSES CONTRIBUTORY HEALTH INSURANCE

THE Grange, a nationwide organization of farmers, stands for a principle of contributory health insurance, the National Conference on Rural Health was told in Chicago on February 4, 1949.

The position of the Grange was outlined by Joseph W. Fichter of Columbus, Ohio, master of the Ohio State Grange, who spoke at the American Medical Association sponsored conference in the Palmer House.

Mr. Fichter said that the Grange recommended:

(1) That the principle of contributory health insurance be the basic method of financing medical care for the large majority of the American people, accompanied by such use of tax funds as may be required to: (a) furnish services which are public responsibilities; (b) supplement health insurance as necessary to provide adequate services by the whole population;

(2) That voluntary prepayment group health plans be organized on a community or collective bargaining level, embodying group practice and providing comprehensive service by every practical means;

(3) The removal of legal restrictions upon voluntary insurance plans on a cooperative basis, such as now exist in a number of states;

(4) That people with comprehensive voluntary health service be exempted from any plan of com-

pulsory health insurance should such a health program be established;

(5) The use of public or private funds to supplement family funds where the rural people cannot afford to pay the total cost of adequate medical care;

(6) Prepaid, nonprofit hospitalization, medical care and the development of cooperative hospitals;

(7) The establishment of adequate public health programs and services in every rural section to improve sanitation, prevent and control disease and promote good health, and the expansion of medical and dental research programs at the federal, state and local levels.

Mr. Fichter said the organization based its health program on the principle that rural people should share fully in the benefits of modern medical science "regardless of their economic status, race or geographical location."

To accomplish this it was recommended that the present authorization of \$75,000,000 under the Hospital Survey and Construction Act be increased. Also favored were adequate appropriations by state legislatures to make the federal act effective. State scholarships to encourage the study of medicine were urged.

A.M.A. 12-POINT HEALTH PROGRAM

A Federal Department of Health

1. Creation of a Federal Department of Health of Cabinet Status with a Secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this Department, except for the military activities of the medical services of the armed forces.

Medical Research

2. Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

Voluntary Insurance

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

Medical Care Authority with Consumer Representation

4. Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

New Facilities

5. Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

Public Health

6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

Mental Hygiene

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

Health Education

8. Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

Chronic Diseases and the Aged

9. Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

Veterans' Medical Care

10. Integration of veterans' medical care and hospital facilities with other medical care and hospital programs and with the maintenance of high standards of medical care, including care of the veteran in his own community by a physician of his own choice.

Industrial Medicine

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home and on the farm.

Medical Education and Personnel

12. Adequate support with funds free from political control, domination and regulation of the medical, dental and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

A.M.A. PROVIDES \$25,000 TO SET UP CHRONIC ILLNESS COMMISSION

CARRYING out another of the objectives of the American Medical Association's 12-point program for the advancement of medicine and public health, the Board of Trustees of the A.M.A. has made available \$25,000 to set up the Commission on Chronic Illness.

The sum, drawn from the A.M.A.'s national education campaign fund, was allotted to the Interim Commission on Chronic Illness, which will set up the permanent commission. The A.M.A. has also provided office space at its Chicago headquarters to the permanent commission, representing voluntary agencies, government agencies, and the public.

Purpose of the commission will be to promote programs for the control of chronic illness in every state.

The A.M.A. program listed "Provision of facilities for care and rehabilitation of the aged and those with chronic disease."

The patient with chronic illness is one of the major challenges to modern society. Sooner or later some form of long term illness affects one or more members in most families of the nation.

A conservative estimate suggests that more than one-sixth of the population is afflicted with some chronic disease. Approximately 2,000,000 persons in the United States are chronic invalids at the present time, and the number is steadily increasing.

The commission is a joint project of the A.M.A., the American Hospital Association, the American Public Health Association, and the American Public Welfare Association, and was recommended by the Section on Chronic Disease of the National Health Assembly.

Dr. James R. Miller, Hartford, Connecticut, member of the Board of Trustees of the A.M.A., is chairman of the Interim Commission and will be a member of the permanent commission.

Other members of the Interim Commission, all of whom will be among the members of the permanent commission of approximately 30, are Dr. Thomas A. McGoldrick, Brooklyn, New York, representing the A.M.A.; Dr. Albert Snoke, New Haven, Connecticut, and J. Douglas Colman, executive director, Maryland Hospital Service, Baltimore, representing the A.H.A.; Dr. Dean W. Roberts, chief, Bureau of Medical Service, Maryland State Health Department, Baltimore, and Dr. Edward S. Rogers, of the Public Health School, University of California, Berkeley, representing the A.P.H.A.

Dr. Ellen C. Potter, Deputy Commissioner for Welfare, State Department of Institutions and Welfare, Trenton, N. J., and Judge Thomas S. J. Waxter, Domestic Relations Court, Philadelphia, will represent the A.P.W.A.

Mrs. Lucille M. Smith, of the Division of Public Health Methods, Public Health Service, Washington, D. C., representing the A.P.W.A. on the Joint Committee of the A.M.A., the A.H.A., the A.P.H.A., and the A.P.W.A., from which the Interim Commission developed, has been loaned by the Federal Security Agency to assist the Interim Commission as executive secretary in establishing the permanent commission.

This coordinated effort in the field of chronic illness is an excellent example of constructive cooperation between public and private agencies in answering one of the greatest and most acute of all social needs.

The permanent commission will include also representatives of the general public, education, churches, hospitals and medicine, agriculture, labor, management, public health, psychiatry, journalism, nutrition, and economics and sociology.

The Interim Commission has suggested the following objectives for the permanent commission:

1. To modify the attitude of society that chronic illness is hopeless; to substitute for the prevailing over-concentration on provision of institutional care a dynamic program designed to prevent chronic illness, to minimize its disabling effects, and to restore its victims to a socially useful and economically productive place in the community.
2. To clarify the problems arising from chronic illness among all age groups, with full realization of its social as well as its medical aspects.
3. To coordinate separate programs for specific diseases with a general program designed to meet more effectively needs which are common to all the chronically ill regardless of the cause or causes of their illness.
4. To clarify the interrelationship of professional groups and agencies now working in the field.
5. To stimulate in every state and locality a well-rounded program for the prevention and control of chronic diseases and for the care and rehabilitation of the chronically ill.

Proposed activities of the permanent commission are:

1. To assemble existing data in order to evaluate and make use of all that is now available and to determine areas requiring further study.
2. To serve as a clearing house for information on laws, programs, experiments, and new developments; to keep all interested groups informed through a newsletter published regularly; and to publish special reports from time to time.
3. To stimulate the development of new methods and techniques in the organization and administration of services for the chronically ill.
4. To develop suggested patterns for integrated community programs.

5. To establish criteria for the appraisal of state and local chronic disease programs and facilities.

6. To give consultation to private and public state, regional, and local agencies interested in planning for the chronically ill.

7. To suggest priorities for the determination

of immediate as against long range needs for the guidance of state and local communities.

8. To explore methods of implementing the recommendations made by the commission.

9. To prepare a report to the American people outlining a comprehensive plan for the prevention and control of chronic disease and for the care and rehabilitation of the chronically ill.

REPORT ON RURAL HEALTH CONFERENCE CHICAGO, FEBRUARY 3-4-5, 1949.

THE American Medical Association's Committee on Rural Health, under the leadership of Dr. F. S. Crockett of LaFayette, chairman, called a meeting of all professional and lay groups interested in rural health problems at the Palmer House in Chicago for February 4 and 5, 1949.

The meeting opened with an address of welcome by Dr. George F. Lull, secretary and general manager of the American Medical Association, immediately followed by Dr. Crockett, who outlined the purposes of the conference: an intensive drive on the part of all interested groups to raise to new high levels the standards and availabilities of medical treatment in rural communities everywhere in America.

First item on the agenda was a sketch of the rural health programs of such interested organizations as the Milk Producers' Federation, The Ohio State Grange, Farmers' Educational and Cooperative Union of America, and the American Farm Bureau Federation.

Mrs. Gladys Edwards, speaking for the Farmer's Educational and Cooperative Union, called for a change in the Hill-Burton Hospital Act to permit a community to contribute labor in the building of a hospital. Miss Evanson, who read the paper in Mrs. Edwards' absence, declared that public health units were basic in giving complete rural health coverage in America.

Mr. H. E. Slusher, chairman of the Medical Care Committee of the American Farm Bureau, opened his discussion by reading a blast against government medicine issued recently following a meeting of leaders of all farm organizations in Washington, D.C., in which those organizations declared themselves unequivocally opposed to government interjecting itself into medicine save for a "minimum of Federal control."

Mr. Slusher called on Medicine to solve its own inadequacies and declared the problem should be solved locally, without government help. Pointing out the experiences in other countries, he maintained that their programs of Government Medicine had "in no way solved the Health problem," while "medical service is now much poorer."

The next speaker in the Friday morning session was Dr. J. S. De Tar, a member of the Michigan

State Society's committee on Rural Health. He stressed the fact that action to solve the rural health problem must occur primarily on the local level, with state and national help of decreasing importance, in that order.

Dr. De Tar described the activities centering around rural health problems in his state, telling how the Michigan Medical Society gave \$2,000 to finance a meeting of some 28 interested co-sponsor groups, who in turn initiated a state health conference. At that meeting a foundation was established, which proceeded to raise \$100,000 in contributions. Part of that money goes to scholarships for medical students who declare themselves willing to practice in rural communities. A list of towns needing physicians, and rural communities needing physicians, was set up to channel young medical school graduates where they were most needed. By skillful lobbying, the Foundation got the Michigan state legislature to increase state hospital facilities by a multi-million dollar construction program.

Meantime, a Michigan State Health Council had been established with a \$22,000 budget given by the State Medical Society and the Michigan Blue Cross and Blue Shield; a permanent director was given to this organization.

Under the stimulus of this program a Commission on Health Care spent an \$8,000 budget surveying the state's needs for such skilled medical associates as nurses, dieticians, technicians, et cetera, while at the same time giving wide distribution to an attractive pamphlet titled *Planning Your Career as a Medical Associate*.

Dr. De Tar told of one community stimulated to raise its own funds to build a health center in order to attract there a badly needed doctor and dentist, along with a corps of nurses. No federal money entered their project.

Meanwhile the rural health program in Michigan had swung into high gear with research done in some 1,000 households throughout the state to determine how much medical care was really necessary. The work of this survey, implemented by a \$12,000 budget, got answers to such basic questions as: Does your family use a medical doctor or an osteopath; do you have medical and

hospital care insurance; what do you think of your doctor?

Out of these and scores of other questions came a partial answer to why people didn't go to their doctors when they really need medical care, as well as a pinpointing of places around the state where the need for medical care was most urgent.

One striking result showed that 70 per cent of the cross section interviewed had never even heard about socialized medicine.

In their stepped-up campaign for rural health, interested organizations spent \$46,000 on radio time in a two year period, and got thousands of dollars more in radio time contributed by interested and helpful radio stations. A motion picture to dramatize the rural health problem cost the Michigan group \$15,000, but estimates indicate the picture has already carried its message to a million people.

On a budget of \$50,000 a series of 30 rheumatic fever stations were set up around the state of Michigan. Already more than 4,000 suspected cases of rheumatic fever have been referred to the specialists at these stations by general practitioners.

An intensive drive to enroll Michiganders in prepayment medical insurance has resulted in a coverage of 1,500,000 under Blue Cross, and 1,300,000 under the Blue Shield Plan. Now under way is a state-wide enrollment campaign under which any family may insure its future medical care for approximately twenty cents per day, the cost of a pack of cigarettes.

A so-called Mediation Committee has been set up in every county in Michigan to receive and judge complaints against the medical profession.

In closing, Dr. De Tar stressed that rural people need to undertake the solution of their own problems of health.

Other subjects discussed at the Friday morning meeting were Environmental Hygiene, by Ernest E. Stebbins, M.D., professor of Public Health, Johns Hopkins University School of Public Health, Baltimore, Maryland; Animal Diseases Affecting Humans, by H. B. Mulholland, M.D., Committee on Rural Health, American Medical Association, Charlottesville, Virginia; Nutrition and the Soil, by Glen W. Bunting, Manager, Central Farmer's Fertilizer Co., Chicago, Illinois.

The 11:30 A.M. time on the agenda went to Aubrey Gates, Associate Director, Cooperative Extension Work, College of Agriculture, University of Arkansas, Little Rock.

Mr. Gates decried a widespread public attitude of expecting the community doctor to take the lead in seeing that hospitals are built. "Its too big a job for the doctor alone," he declared. "The public now must step in to help."

He suggested that a department of hospitals be set up in all state governments so the untrained but enthusiastic lay people who want to help build community hospitals will have proper guidance. The Extension head pointed out that

states which failed to take steps to set up a hospital department could expect to find the Federal Government moving in to handle this most necessary of problems which rightfully belongs at the local and state levels only.

The Friday morning session ended with a sketch of the "General Practitioner in Rural Practice," by Ward Darley, Jr., M.D., Executive Dean, Health Sciences and Services, University of Colorado School of Medicine, Denver.

Dr. Darley called the patient-doctor relationship the most essential matter of medical practice, adding that a maximum use of the doctor's own personality as a therapeutic agent is necessary.

Conversely, he took the stand that the modern-day trend toward specialization led to a most harmful impersonal type of contact. Agreeing that medical efficiency is now so great that a doctor need spend only a minimum amount of time with his patient, Dr. Darley warned that too little time with the patient was harmful. Even health insurance, as a kind of a third party, dilutes the doctor-patient relationship, according to him.

The Dean then spoke of preventative medicine as it should be practiced by the rural doctor, delineating four phases:

- a. Preventative medicine to maintain the patient in good health.
- b. Psychiatric training to catch early neuroses.
- c. An interest in the patient and his family, enabling the doctor to reorient the entire family in the case of serious illness among its members.
- d. Knowledge of Geriatrics and its applications.

Dr. Darley mentioned in his closing remarks that the trend toward specialization existed, in his opinion, because many medical school graduates feel uncertain about meeting the multitude of problems and emergencies in general practice.

On Friday afternoon there were five round table meetings: Cooperative Health Programs for Rural Areas; Environmental Hazards; Health Education—Individual and Community Responsibility; the General Practitioner in Rural Practice; and Nutrition and the Soil.

Perhaps the most interesting and controversial panel from a news standpoint was that on Cooperative Health Programs for Rural Areas, where there was considerable divergence of opinion on the definition of what a "cooperative hospital" is and what it is not.

Mr. Chester Starr, the chairman, described the workings of the Cooperative Health Program in Missouri. Opinion in Missouri was divided over whether such programs should be led by doctors or lay groups. At all events, Mr. Starr suggested that the first step in creating a Health Council should be the choosing of community leaders for the preliminary meeting; organizations, he pointed out, will follow naturally, since the leaders are always key men in such organizations.

Once established, the Health Council in Missouri offered field service to help set up County Health

Councils. The idea of all this, according to Mr. Starr, is to "engender a desire in the people of a county" to have a Health Council, without any sign of dictation from the state level. He observed that a full time county health official was necessary to carry the brunt of the County Health Council organization and its projects.

The subject of cooperative hospitals brought out an essential distinction: The cooperative hospital is a nonprofit institution, while the proprietary hospital is theoretically profitable.

Both in the formal presentation of papers and the general discussion it was brought out that cooperative hospitals need the support of the medical profession. Doctors need to realize that such cooperatives are in no way socialized medical practice. The practice of some medical societies of not allowing their doctors to practice at cooperative hospitals was decried. Anyone interested in studying what is and what is not a true "cooperative" is referred to the Duke University Contemporary Law Review quarterly for last fall for precise definitions of terms.

The Environmental Hazards section concerned itself with the control of disease in animals and the prevention of the spread of such animal diseases to humans. It was suggested the veterinarians should take a much greater part in solving this problem. Incidentally, the rate of bovine tuberculosis is now at an all-time low of $\frac{1}{2}$ of 1 percent in the bovine population. Our number one problem remains brucellosis, in goats, swine and cattle. The incidence of brucellosis traceable to goat's milk is very low, but the handling of diseased meat of swine by packing house workers and butchers is a considerable problem, while unpasteurized milk as a spreader of the disease occupies first place.

Attention was called to one serious local problem. In many communities, due to a loophole in the milk ordinances, unpasteurized milk may be used in butter, cheese and ice cream, threatening the entire community with brucellosis from that unsuspected source.

Dangers of farming are clearly shown in these figures:

18,000	accidental deaths on the farm annually:
6,500	of these occur in farm homes,
7,000	of them are traffic accidents,
4,500	are attributable to farm machinery.

Meanwhile, there are more than 225,000 serious injuries on the farm every year in addition to the fatalities. Most injuries come from the removal of guards and safety devices from farm machinery. The participants in this panel concluded that a program of farm safety should be inaugurated to cut this alarming toll.

Statistics prove that the farm lags behind the city in controlling disease of environmental origin. As one speaker said: "On most farms they still take better care of the cattle than they do of the kids."

Rural electrification, with its running water, toilets, refrigeration and washers, gets a major share of the credit for raising environmental health standards on the farm in the last few years.

The Health Education section stressed the necessity of cooperation between doctors, public health officials, farm groups, newspapers and radio stations, and schools, in getting across to the public sane ideas of health education.

The panel discussing the general practitioner in rural practice concluded that rural communities could get doctors if they would provide an environment congenial for their work and their families, as well as orientation and community assistance. Most young medical school graduates, according to the panel, get the idea they'll be buried alive in a rural community. What is needed is a thorough selling job that the life of a rural practitioner has its benefits, even though they may differ markedly from those of the city doctor.

Older doctors were warned that they should not make it difficult for a young man to come into their community by excluding him from practice in nearby hospitals or in any other way failing to extend him all help and courtesies.

Section five, on Nutrition and the Soil, concluded that good food can come only from top quality soil, full of essential elements. Soil conservation must go hand in hand with health conservation.

Saturday morning was occupied with reports of the round table committees, followed by a luncheon. The audience was introduced to Dr. W. L. Pressly, chosen General Practitioner of the Year. Dr. Pressly, who comes from Due West, South Carolina, told the audience that in his opinion no young doctor should enter on the practice of medicine alone; group practice was the thing. "Associated practice," said Dr. Pressly, "gives greatest service to the patient and greatest satisfaction to the doctor." The General Practitioner of the Year voiced his belief that 85 percent of patients could get complete satisfaction out of the various talents and abilities of a group of general practitioners working together; the other 15 percent of patients would undoubtedly have to be referred to specialists.

Dr. R. L. Sensenich of South Bend, president of the American Medical Association, listed on the roster of speakers for the Saturday luncheon, was unavoidably absent due to his having been called to Washington, D.C. Speaking in his place was Dr. Elmer Henderson, Chairman of the Board of Trustees, the American Medical Association. He complimented the assembled guests on the action taken Friday afternoon in adopting an eleven point resolution assuring good medical service to rural communities.

(1) State and public health services for general community hygiene and communicable disease control; public health nursing, well-baby conferences and clinics;

(2) The Hill-Burton Hospital Construction Act operating where the people of a community demonstrate sufficient desire for such facilities.

(3) Medical scholarships provided by medical associations, farm bureaus and through legislative appropriations to be given to deserving boys and girls, without discrimination, for medical and nurses education where they agree to practice for a time in rural areas.

(4) Agricultural school extension services where they utilize their home demonstration courses, 4-H clubs, health specialists whose special duty it is to organize health councils in the counties for the purpose of health education and where appropriate to apply for Hill-Burton facilities; the teaching of better farm methods, better soil conservation and soil building practices, better grain and productive livestock methods such as calf and pig clubs, five-acre club lots, better cost accounting and business methods;

(5) Parent-Teacher Associations where they encourage school children examination for hearing, sight, heart, hernia, immunization, school hygiene, as well as physical education.

(6) Special health groups such as tuberculosis, polio, cancer, heart, which do considerable educating within narrow limits.

(7) The application of voluntary prepaid medical and hospital care plans to rural communities, taking into consideration that several of the large farm groups have their own indemnity prepaid medical and hospital plans;

(8) A promotion of state and county health councils, the medical profession acting cooperatively with organized farm groups and other civic, church and school organizations and special health groups for the purpose of health education and health activities of local character;

(9) A plan to bring the medically indigent, or low income, farmer into voluntary prepaid medical plans, which may involve some state financial aid;

(10) Use of the health education programs of farm groups;

(11) Encouragement of the civilian population, as distinguished from governmental official action, to help itself.

Dr. Henderson spoke briefly about government medicine, saying: "Whenever politics steps into medicine, medicine deteriorates, and deteriorates rapidly." He said medical education in Europe is practically nil today, and that is what will happen to America if government medicine comes about. His concluding remark was: "We are fighting this fight for the great American people, not for selfish reasons."

Main speaker of the afternoon was John O. Christianson, Ph.D., Superintendent of the School of Agriculture, University of Minnesota. Dr. Christianson also dealt with government medicine along three themes, typified by these quotations:

"Individual initiative built America—not a desire to have the Government do everything."

"The high degree of American medical care has come by individual initiative, not government initiative."

"History shows countries in decline suffer from increasing governmental interference and regimentation."

The conference was concluded by this speech and a few words of thanks to the participants from Dr. Crockett, Chairman of the A.M.A. Committee on Rural Medical Care.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—JANUARY, 1949

DISEASE	Jan., 1949	Dec., 1948	Nov., 1948	Jan., 1948	Jan., 1947
Blastomycosis	1	0	0	0	0
Chickenpox	681	313	368	662	575
Conjunctivitis	1	0	0	0	1
Diphtheria	38	45	38	44	58
Dysentery, amebic	1	0	11	0	0
Encephalitis	6	1	4	3	5
Erysipelas	2	0	1	1	6
Impetigo	3	1	9	5	12
Influenza	134	15	105	94	69
Measles	267	118	93	1881	81
Meningitis, Unclassified	9	2	3	5	7
Influenzal	3	0	2	2	4
Meningococcal	4	4	1	5	5
Pneumococcal	2	0	0	0	1
Streptococcal	1	0	0	0	1
Lymphocytic-choreo	1	0	0	0	0
Enterococci coli	1	0	0	0	0
Tubercular	2	0	0	0	0
Mumps	193	112	72	558	117
Pneumonia	83	53	65	72	91
Poliomyelitis, Paralytic	2	6	15	6	0
Unspecified	2	3	2	0	12
Puerperal sepsis	1	0	0	0	0
Rabies in animals	83	65	54	47	0
Rheumatic fever	2	3	1	0	0
Rubella	12	4	4	11	8
Scabies	4	0	0	4	0
Scarlet fever	250	217	136	286	479
Tinea capitis	5	10	6	40	4
Tuberculosis, Pulmonary	238	158	137	214	227
Other forms	16	10	6	15	21
Tularemia	1	23	10	3	24
Typhoid fever	3	1	3	0	7
Whooping cough	80	46	68	164	132

MONTHLY REPORT — FEBRUARY 1949

Diseases	Feb. 1949	Jan. 1949	Dec. 1948	Feb. 1948	Feb. 1947
Brucellosis	2	0	0	4	8
Chickenpox	524	681	313	579	498
Conjunctivitis	10	1	0	1	1
Diarrhea, infectious	1	0	0	4	0
Diphtheria	29	38	45	65	50
Dysentery, amebic	4	1	0	0	0
Encephalitis	2	6	1	3	6
Erysipelas	4	2	0	2	4
Food Poisoning	1	0	0	0	1
Impetigo	1	3	1	7	5
Influenza	52	134	15	110	162
Measles	372	267	118	2707	162
Meningitis, Unclassified	6	9	2	3	3
Influenzal	2	3	0	2	3
Meningococcal	8	4	4	3	3
Pneumococcal	1	2	0	2	0
Mumps	163	193	112	766	139
Pneumonia	151	83	53	75	37
Poliomyelitis, Paralytic	2	2	6	0	
Unspecified	2	2	3	1	2
Rabies in animals	74	83	65	63	--
Rheumatic fever	3	2	3	0	0
Rubella	70	12	4	32	0
Scabies	6	4	0	0	0
Scarlet fever	284	250	217	361	473
Septic sore throat	1	0	0	7	24
Tinea capitis	72	5	10	9	59
Tuberculosis, Pulmonary	244	238	158	149	139
Other forms	15	16	10	20	3
Tularemia	2	1	23	2	5
Typhoid fever	3	3	1	5	9
Whooping cough	112	80	46	161	181

Medical Panorama by the ASSOCIATE EDITOR

COSTS OF MEDICAL CARE COMPARED WITH COST OF LIVING INDEX

Costs of medical care have not risen as fast as the cost of living, a comparison of the 1948 Consumers' Price Index with a preliminary index of medical care prices of the U. S. Bureau of Labor Statistics shows.

Writing in the February 26 issue of *The Journal of the American Medical Association*, Frank G. Dickinson, Ph.D., Chicago, director of the Bureau of Medical Economic Research of the American Medical Association, says the bureau estimates from U. S. Bureau of Labor Statistics figures that the index of medical care items will stand at 141 for 1948.

The final report of the U. S. Bureau of Labor Statistics places the Consumers' Price Index for 1948 at 171.2. The base period 1935-1939 equals 100 in computing the entire index, of which the index of medical care items is a part.

Preliminary figures of the Bureau of Labor Statistics for costs of medical care in 1948 are:

General practitioners' services, 136; surgeons' and specialists' services, 136; dental care, 146; eyeglasses, 124; hospital rates, 212; and prescriptions and drugs, 122.

Figures of the Bureau of Labor Statistics for these items in 1947 were 130.3; 129.4; 137.4; 118.6; 179.6; and 115.4, respectively. The entire cost of living index for 1947 was 159.2.

"The most significant change is in hospital rates, which soared from 179.6 in 1947 to 212 in 1948," Dr. Dickinson comments.

"Prices for laboratory and other services rendered by hospitals are not sampled; hence the hospital index covers primarily room rates. The hospital is uniquely exposed to the forces of inflation. It buys goods and services and sells services soon after purchase. Its costs are not stabilized by such customary accounting items as depreciation and taxes because most hospitals are public institutions.

"Hence the changes in current prices of food and fuel and in hourly wage rates are potent in changing hospital room rates charged to patients because there are no other costs of importance.

"The sharp increase in the index of hospital room rates for 1948 over 1947 reflects to some extent the failure of hospitals to raise their rates earlier. The recent decline in prices of farm products has not yet materially reduced the operating costs of hospitals."

The estimates should "set at rest a good many wild and irresponsible statements about the ex-

orbitantly high prices being paid for medical care," adds an editorial appearing in the same issue of *The Journal*.

BIRTHS REMAIN HIGH IN 1948

The second largest number of births in the history of this country occurred during 1948. This information, released by Federal Security Administrator Oscar R. Ewing, summarized data prepared by the National Office of Vital Statistics of the Public Health Service.

The number of live births registered during 1948 was estimated at 3,559,000 or only about 4 percent below the all-time high of 3,699,940 for 1947. Of even greater significance are the figures which take into consideration the unregistered births. The total number of births (registered and unregistered combined) was estimated at 3,715,000 for 1948 and 3,876,000 for 1947. Only 8 years earlier, in 1940, the last prewar year, the figure was little more than 2½ million (2,558,000).

The 1948 estimated birth rate of 24.4 per 1,000 population was about 5 percent below the final rate of 25.8 for 1947, but exceeded the 1946 rate (23.3) by almost 5 percent. (These rates and all other figures which follow are based on registered births.)

Striking changes have occurred in the birth rate during the postwar period 1946-48. Demobilization beginning in the last half of 1945 was reflected by extraordinarily high birth rates in the latter part of 1946. In 1947 the monthly rate declined from the peak rates experienced at the end of 1946 but was nevertheless at a high level throughout the year. The rates in the last half of 1948 were significantly higher than in the earlier months and about equalled the rates in the last half of 1947.

The state rates for 1947 ranged from a high of 37.2 (per 1,000 population present in area) for New Mexico to a low of 22.8 for New York. The birth rate for half of the states and the District of Columbia fell within the range 25.0 to 30.0. The rates for fourteen states were below 25.0, while in ten states they exceeded 30.0.

Changes in birth rates between 1940 and 1947 are as follows: Fifteen states had increases of 50 percent or more; fifteen increases of between 40 and 50 percent; fourteen between 30 and 40 percent; and, four between 20 and 30 percent. Greater proportionate increases were recorded in those areas which for many years have consistently had comparatively low birth rates.

News Notes

Dr. Victor F. Albright has opened an office for the practice of surgery in the Burr Building in New Castle. He is a graduate of Indiana University School of Medicine and a veteran of World War II. He served for three years in the armed forces, as a flight surgeon with the 323rd bombardment group in the European theater. Since his release from the service, Doctor Albright has been a resident in surgery at the Indiana University Medical Center.

Dr. Paul A. Clouse has opened an office at 721 Edgar Street in Evansville for the practice of internal medicine and diagnosis. He has just completed a residency in medicine at the Scott and White Clinic in Temple, Texas. A graduate of Indiana University School of Medicine, Doctor Clouse spent four years in the service, as commanding officer of an air evacuation squadron in the European theater.

Announcement has been made of the opening of an office for the practice of medicine by Dr. Marjorie Galliher at 115 South Liberty Street, in Muncie.

Dr. John C. Glackman, Sr., has moved to Rochester, from Denver, Colorado, and has opened an office for the practice of medicine and surgery. He had practiced formerly in Rockport for forty years, prior to his entry into service with the Medical Corps, where he served at the Fitzsimmons General Hospital, in Denver.

Indiana's General Practitioner of the Year, Dr. David D. Oak, of La Crosse, received further honor recently by being featured in a coast-to-coast NBC broadcast of the "This is Your Life" program, which originated in Hollywood, California. The program portrayed his life as a Hoosier country doctor during the past thirty-eight years.

Dr. John Shively, of Knightstown, has opened an office in Hagerstown for the practice of medicine. He has been practicing in Knightstown since last summer, when he completed his internship at the Methodist Hospital in Indianapolis. He is a 1947 graduate of the Indiana University School of Medicine.

Dr. Richard A. Theye, a graduate of Indiana, University School of Medicine, has been awarded a Lilly Research fellowship for investigative work in anesthesia at the Indiana University Medical Center. Doctor Theye will continue the research under the supervision of Dr. V. K. Stoelting, chairman of the university's department of anesthesia.

COMING MEDICAL MEETINGS

Indiana State Medical Association, Indianapolis, September 26, 27, 28, 29, 1949.

American Medical Association, Annual Session, Atlantic City, June 6, 7, 8, 9, 10, 1949.

American Association of Anatomists, Philadelphia, April 13-15. Dr. Normand L. Hoerr, 2109 Adelbert Road, Cleveland 6, Secretary.

American Association of Industrial Physicians and Surgeons, Detroit, Book-Cadillac and Statler Hotels, April 5-9. Dr. Edward C. Holmblad, 28 E. Jackson Blvd., Chicago 4, Managing Director.

American Association of Pathologists and Bacteriologists, Boston, April 15-16. Dr. Howard T. Karsner, 2085 Adelbert Road, Cleveland, Secretary.

American Association on Mental Deficiency, New Orleans, Hotel Roosevelt, April 27-30. Dr. Neil A. Dayton, Box 51, Mansfield Depot, Conn., Secretary.

American Broncho-Esophagological Association, Chicago, Drake Hotel, April 18-19. Dr. Edwin N. Broyles, 1100 N. Charles St., Baltimore 1, Secretary.

American College of Allergists, Chicago, April 14-17. Dr. Fred W. Wittich, 423 LaSalle Medical Bldg., Minneapolis 2, Secretary.

American Congress of Physical Medicine, Netherland Plaza, Cincinnati, September 6, 7, 8, 9, 10, 1949.

American Goiter Association, Madison, Wisconsin, May 27, 28, 1949. Dr. T. C. Davison, Atlanta, Georgia.

American Industrial Hygiene Association, Detroit, Book-Cadillac and Statler Hotels, April 5-7. Dr. Henry F. Smyth, Jr., 4400 Fifth Ave., Pittsburgh 13, Executive Secretary.

American Orthopsychiatric Association, Chicago, Stevens Hotel, April 4-6. Nina Ridenour, Ph.D., 25 W. 54th St., New York 19, Secretary.

American Physiological Society, Detroit, April 19-22. Dr. Milton O. Lee, 2101 Constitution Ave., Washington 25, D. C., Executive Secretary.

American Society for Experimental Pathology, Detroit, April 18-22. Dr. Frieda S. Robschtein-Robbins, 260 Crittenden Blvd., Rochester, N. Y., Secretary.

American Society for Pharmacology and Experimental Therapeutics, Detroit, April 18-22. Dr. Harvey B. Haag, Medical College of Virginia, Richmond 19, Secretary.

American Society for Research in Psychomatic Problems, Atlantic City, Chalfonte-Haddon Hall, April 30-May 1. Dr. Sydney G. Margolis, 714 Madison Ave., New York 24, Executive Secretary.

American Society of Biological Chemists, Detroit, April 17-22. Dr. Otto A. Bessey, 1853 W. Polk St., Chicago 12, Secretary.

American Surgical Association, St. Louis, April 20-22. Dr. Nathan Womack, University of Iowa, Iowa City, Secretary.

International Congress on Rheumatic Diseases, Waldorf Astoria, New York City, May 30-June 3, 1949. Dr. Ralph Pemberton, 1901 Walnut St., Philadelphia 3.

Northern Tri-State Post-Graduate Medical Association, Fort Wayne, April 12, 1949. Dr. Don F. Cameron, Wayne Pharmacal Building, Fort Wayne.

AMERICAN BOARD OF PREVENTIVE MEDICINE AND PUBLIC HEALTH

The American Board of Preventive Medicine and Public Health, Incorporated, was approved by the Advisory Board for Medical Specialties and by the Council on Medical Education and Hospitals of the American Medical Association, on February 6, 1949, and is now prepared to receive applications for certification in this specialty.

Applications will be received by the Board for certification by examination, and also for admission to the Founders Group. Information may be obtained by addressing the secretary of the Board, Ernest L. Stebbins, M.D., 615 N. Wolfe St., Baltimore 5, Maryland.

The Indiana Academy of Ophthalmology and Otolaryngology will hold its Annual Meeting at Bloomington, on May 4 and 5, 1949. Scientific papers will be read by Dr. Milton E. Erdel, Frankfort, Dr. Mortimer Mann, Indianapolis, Dr. Robert M. Dearmin, Indianapolis, and Dr. Carl J. Rudolph, South Bend. Guest speakers will be Dr. O. E. Van Alyea of Chicago, and Dr. B. Y. Alvis of St. Louis. All members of the Indiana State Medical Association limiting their practice to ophthalmology and/or otolaryngology are invited to attend this meeting. Special entertainment for the members and guests of the Academy and their ladies have been arranged. A copy of the program may be secured from Dr. M. S. Harding, Secretary-Treasurer, 308 Hume Mansur Building, Indianapolis 4.

NATIONAL ODD SHOE EXCHANGE

The financial difficulties of people who have feet which do not match, or who have only one foot, may possibly be alleviated by the services of the National Odd Shoe Exchange. Persons who must buy two pairs of shoes, a pair of one size to fit one foot, and a pair of another size to fit the other foot, are afflicted with double shoe bills, unless they can find someone else with feet of the opposite combination of sizes, and trade shoes with them.

The National Odd Shoe Exchange does not deal in shoes, but does register and cross-index information concerning persons whose feet are not mates, and in most instances is able to match up two such people of the same sex and tastes, and approximately the same age, so that exchange of their extra shoes is possible. The exchange also performs the same service for those who require only one shoe.

This is a nonprofit enterprise and is conducted by Miss Ruth C. Rubin, who started the project in an effort to solve her own problem of unmatched feet. An annual registration fee of \$3.00 is charged. The address is: National Odd Shoe Exchange, 6267 Clemens Avenue, St. Louis 5, Missouri.

INFERTILITY CLINIC

The Maternal Health League of Indianapolis has announced the opening of a clinic for the treatment of infertility at 312 E. Washington Street, Indianapolis. Patients who require diagnostic measures and treatment for the alleviation of sterility, and who cannot afford this service from private practitioners, are cared for by the new clinic. Doctors may refer patients in this classification to the clinic for complete study.

Since the geographic area which can be served by the clinic is limited by the patients' ability to travel, the Maternal Health League will provide information as to other diagnostic and treatment facilities over the state for those too far removed from Indianapolis.

The medical staff of the clinic, under Dr. Dan Talbott, Medical Director, offers training in diagnostic methods and technique to any interested physicians.

THIRTEEN SCHOLARS IN MEDICAL SCIENCE APPOINTED BY MARKLE FOUNDATION

Thirteen young scientists have been appointed as the second group of Scholars in Medical Science, under the plan begun in 1948 by the John and Mary R. Markle Foundation to assist qualified men and women wishing to remain in academic medicine. The scholars were selected from candidates nominated by accredited medical schools in the United States and Canada and interviewed by regional committees appointed by the foundation. The sum of \$325,000 has been appropriated for their support, to be allotted in grants of \$25,000 each at the rate of \$5,000 a year, to the medical schools in which they now hold faculty appointments.

A total of twenty-nine doctors have now received appointments as scholars, John M. Russell, executive director of the foundation, announced. It is expected that fifty will be appointed during the five-year program and that a total of \$1,250,000 will be appropriated toward their support.

TRAINING COURSE IN POLIOMYELITIS

The Western Reserve University School of Medicine offers the following training courses in poliomyelitis at the Department of Contagious Diseases, at the City Hospital in Cleveland, Ohio, under the direction of John A. Toomey, M.D., professor of Clinical Pediatrics and Contagious Diseases:

For Physicians: 5½-day course.

- a. 1st course: July 18 to 23, 1949, inclusive,
- b. 2nd course: August 8 to 13, 1949, inclusive,
- c. 3rd course: August 29 to September 3, 1949, inclusive.

These courses will consist of lectures, demonstrations, conferences, discussions, and practical applications. Physicians who wish to attend for a longer time, between October and April, may inquire about the possibility of such a special course by writing directly to Dr. John A. Toomey.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Atlantic City, June 2, 1949. Candidates for Fellowship in the College, who would like to take the examinations, should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Fifteenth Annual Meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, June 2-5, 1949. An interesting scientific program has been arranged for this meeting, and speakers from several other countries are scheduled to appear.

A Hospital for White County

White County, one of the few remaining counties in Indiana without hospital facilities, is awakening to her need. Not since Dr. H. W. Greist closed his private hospital in 1920 to go to Point Barrow, Alaska, to take charge of the Presbyterian Hospital of the Arctic, has there been a successful attempt to organize one locally. Monticello doctors some years since organized a stock company with this in view, but disagreements followed, with abandonment of the proposition and with ill feelings engendered.

The Junior Chamber of Commerce now is attempting to inaugurate legally a movement which it is hoped will result in a county hospital located in Monticello. The White County Medical Society, now composed of but five men, are quietly collaborating. All other doctors within White County are either nonmembers or are associated with some adjoining county society.

ARMY MEDICAL CORPS SPECIALISTS

As of January 25, 1949, 143 Regular Army Medical Corps officers and 10 civilian component officers on active duty were certified as diplomates of American Specialty Boards. This represents an increase of 51 from the date of the last published survey, September 1, 1947.

Specialists to fulfill current requirements of the Army are needed in all fields. In the specialty fields of allergy, cardiology, gastro-enterology, pulmonary diseases and neurosurgery, the Army still does not have a Board certified specialist although officers are in training in each of these fields to enable them to reach eligibility for Board examinations.

Commissions in the Medical Corps, both Regular Army and Reserve, up to and including the rank of Lieutenant Colonel, are available in these fields for qualified civilian physicians, depending upon length of professional experience and subject to Army Regulations.

Correspondence should be addressed to National Military Establishment, Department of the Army, Office of the Surgeon General, Technical Information Office, Washington 25, D.C.

PEDIATRIC POSTGRADUATE COURSE

A Pediatric Postgraduate Course will be held at the Children's Hospital, Louisville, beginning May 5, 1949, and ending June 23, 1949. The meetings will be from 9 A.M. to 12-Noon on the eight consecutive Thursdays. An invitation is extended to all physicians to attend this course. Inquiries should be sent to W. W. Nicholson, M.D., 1974 Douglass Boulevard, Louisville 5, Kentucky.

PROGRAM

Indiana Society of the American Society of Anesthesiologists

The Indiana Society of the American Society of Anesthesiologists will conduct its initial Spring Meeting on Wednesday, April 27, 1949, at Indiana University Medical Center, Indianapolis.

All members of the Indiana Society are urged to attend. Nonmember physicians are invited to hear the program, without payment of registration fee.

This is the first of what is planned as a series of annual meetings of the Society. Plans will be perfected at this year's session for future clinics and lecture programs in anesthesiology, and a good attendance of members is being encouraged for this purpose.

The program for this year is tentatively announced as follows:

- 8:00 to 8:30 Registration at Registrar's Office, School of Medicine.
- 8:30 to 10:30 Anesthesia Clinics, University Hospitals Auditorium, School of Medicine.
- 10:45 to 11:00 *Opening Remarks of Welcome*, John VanNuys, M.D., Dean, Indiana University School of Medicine.
- 11:00 to 11:30 *What the Surgeon Expects from the Anesthesiologist*, Harris B. Schumacher, M.D., Chairman, Department of Surgery, Indiana University School of Medicine.
- 11:30 to 12:00 *Reports on Clinical Experience with Dimethyl Ether of d-Tubocurarine Iodide (Lilly)* by members of Indiana University Department of Anesthesia.
- 12:15 to 1:30 Luncheon, Doctors' Dining Room, Riley Hospital.
- 1:45 to 2:15 *Anesthetic Problems in Pediatric Surgery*, William McQuiston, M.D., Peoria, Illinois, Visiting Anesthesiologist at Children's Memorial Hospital, Chicago.
- 2:30 to 3:00 *Advantages and Disadvantages of Intravenous Anesthesia*, R. Charles Adams, M.D., C.M., M.S. (Anes), F.A.C.A., Associate Professor of Anesthesiology, Mayo Clinic.
- 3:15 to 3:45 *Circulatory Complications During Surgery*, Stuart C. Cullen, M.D., Professor of Anesthesia, University of Iowa.
- 4:00 to 4:30 *Factors Governing Choice of Agents and Techniques in Anesthesia*, W. Allen Conroy, M.D., Head of Department of Anesthesia, St. Lukes Hospital, Chicago.
- 6:00 to 8:00 Dinner and Address in Doctors' Dining Room, Riley Hospital. Address—*Recent Advances in Analgesic Drugs*, K. K. Chen, M.D., Research Department, Eli Lilly Company.

Joseph F. Ferrara, M.D., a 1941 graduate of Indiana University School of Medicine, has opened an office for the practice of surgery at 807 Hume Mansur Building, in Indianapolis. Doctor Ferrara spent three and one-half years in the Army.

James O. Price, M.D., has announced the opening of an office at 906 Hume Mansur Building, in Indianapolis, for the practice of surgery. A 1942 graduate of Indiana University School of Medicine, Doctor Price has just completed a residency at St. Vincent's Hospital in Indianapolis. He spent two years in the Army, and was separated from service with the rank of captain.

A 1942 graduate of the University of Tennessee School of Medicine, **Dr. J. C. Manning** has begun the practice of surgery at 601 Hume Mansur Building in Indianapolis. He served his residency at Indiana University Medical Center.

ROYALTON STEEPLECHASE

The Royalton Steeplechase Association is a non-profit organization, formed to promote a yearly steeplechase event. Last year was the first running of this event, and in spite of a downpour of rain, it was a most enjoyable afternoon for horse lovers and horse racing fans.

The event will be held again this year near Royalton on the farm of Mr. Wells Hampton. The date is June 11, 1949, and the first event begins at 1:30 P.M. This year there will be five events, three of which will be steeplechase events, jumping either post and rail or brush and water. The other two events will be two flat races.

Tickets may be purchased prior to the event or the day of the event, and a few patron's boxes are still available. These boxes accommodate eight persons and cost \$100.00. General admission is \$1.00 per person.

At a meeting of the Indiana Academy of General Practice on February 9, **Dr. Lester D. Bibler**, of Indianapolis was re-elected president, and **Dr. Maurice V. Kahler**, of Indianapolis, was chosen president-elect. Doctor Kahler's term of office will begin in 1950. **Dr. Norman R. Booher**, of Indianapolis, was re-elected secretary-treasurer.

DR. MEIROWSKY JOINS MEDICAL FACULTY

Dr. Emil Meirowsky has accepted an appointment to the staff of the Indiana University School of Medicine, as research assistant in surgery (oncology). The investigations which Dr. Meirowsky has pursued for years in his native Germany and in England are being carried on at the university. He served as professor of dermatology and syphilology at the University of Cologne for thirteen years, going to England in 1938, where he was the public health officer for Surrey County and dermatologist at the Royal Surrey County Hospital. Dr. Meirowsky's investigative work is supported by a grant from the Indiana Elks' Association through the Indiana Cancer Society.

FIRST ANNUAL SCIENTIFIC ASSEMBLY OF AMERICAN ACADEMY OF GENERAL PRACTICE A HUGE SUCCESS

The first annual scientific assembly of the American Academy of General Practice, held March 7, 8 and 9 in Cincinnati, was an outstanding success. Total registration was over 3,400. Doctors came from all over the country and from as far as Oregon, Washington and California. Observers were present from Canada.

Advance registration began on March 6, and the House of Delegates met for its first session on the same day. Delegates from Indiana were O. T. Scamahorn, Pittsboro, and William Tindall of Shelbyville. Problems of current importance not only to G.P.'s but to the whole medical profession were discussed in the general assembly and the House of Delegates. The problem of compulsory health legislation occupied a predominant place in the discussions. Unity among doctors of all categories was stressed, as was the predominance of the local, state and national medical societies in all activities.

All scientific sessions were held with "standing room only" audiences. Outstanding speakers and teachers were heard—including such men as Walter Alvarez, Karl Meyer and Philip Thorek, among others, totaling twenty, all of whom were distinguished men. The speakers, needless to say, were pleased and gratified with the large and enthusiastic attendance.

Three Indiana doctors were honored with national committee appointments. **Dr. Lester Bibler**, who is a national director of the A.A.G.P. and president of the I.A.G.P., was reappointed as chairman of the Education Committee; **Dr. Norman R. Booher** was appointed to the Committee on Public Relations and Legislation; and **Dr. Arthur N. Jay** was appointed to the Publications Committee. One hundred eighteen Indiana doctors attended the meeting, thirty-two of them being from Marion County.

On Tuesday night a banquet was held which overflowed from the "Hall of Mirrors" of the Netherland Plaza into the balcony above and into the Pavilion Caprice. One thousand five hundred doctors and their wives were entertained by artists from the Conservatory of Music of Cincinnati, and by an all G.I. mens' chorus.

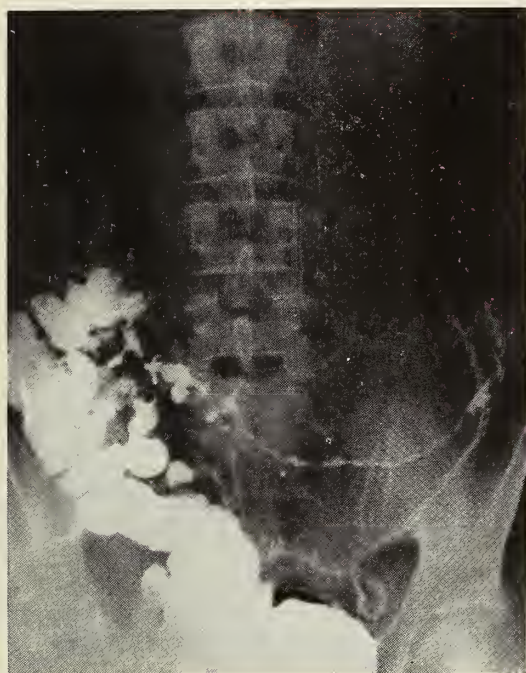
More than 600 wives of members also made the trip to Cincinnati. They were entertained on Monday by a sight-seeing tour, followed by a tea at the Taft Museum, and on Tuesday by a brunch and fashion show held in the Netherland Plaza hotel. A dance following the banquet completed the social part of the meeting.

An interesting side-light to the assembly was furnished by many of the exhibitors. Their reactions were exemplified by one man who said, "I've been going to conventions now for twenty-two years and this is without a doubt the best and most enthusiastic one I've ever attended."

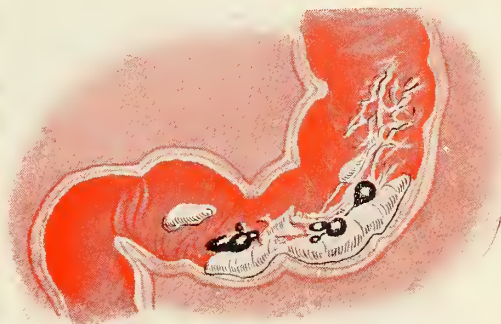
TREATMENT OF CONSTIPATION IN **mucous colitis**

"The treatment of the constipation in mucous colic does not differ from the treatment of uncomplicated constipation. It is, as always, of great importance to avoid irritating aperients, . . . The stools should be rendered soft and more bulky and therefore more easy to expel with . . . and unirritating vegetable mucilages."

—Hurst, A., in Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



By providing soft, demulcent, water-retaining, mucilloid bulk, Metamucil—the "smoothage" treatment of constipation—promotes a return to normal elimination.



METAMUCIL® is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

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The Chamber of Commerce of the United States is presenting a **National Institute on Community Health** on April 7 at the Netherland Plaza Hotel in Cincinnati. The subject to be discussed is "Has Your Community Kept Pace with the Nation's Health Progress?" All physicians are invited to attend. There is no charge.

The American Congress of Physical Medicine will hold its twenty-seventh annual scientific and clinical session September 6, 7, 8, 9 and 10, 1949, inclusive, at the Netherland Plaza Hotel, Cincinnati, Ohio. Scientific and clinical sessions will be given on the days of September 6, 7, 8, 9 and 10, 1949. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 6, 7, 8 and 9. These courses will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapy technicians who are registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of "The Foundation Prize." Authors of papers on Obstetrical or Gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N.E., Atlanta, Ga.

American Board of Obstetrics and Gynecology, Inc.

The general oral and pathology examinations (Part II) for all candidates will be conducted at Chicago, Illinois, by the entire Board from Sunday, May 8, through Saturday, May 14, 1949. The Hotel Shoreland in Chicago will be the headquarters for the Board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Shoreland.

Candidates for re-examination in Part II must make written application to the Secretary's office not later than April 1, 1949.

Candidates in military or naval service are requested to keep the Secretary's office informed of any change in address.

Applications are now being received for the 1950 examinations. Application forms and Bulletins are sent upon request made to American Board of Obstetrics and Gynecology, Inc., 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Dr. William C. Schafer has announced the opening of an office in Washington for the practice of ophthalmology and otolaryngology. A graduate of Indiana University School of Medicine in 1943, he served his internship at Indianapolis General Hospital. Following his internship, Doctor Schafer spent two years in the service of the Army Medical Corps. After the war, he took postgraduate work in surgery and diseases of the eye at St. Petersburg, Florida, and served a two-year residency in ophthalmology and otolaryngology at Indianapolis General Hospital.

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POLIO NURSING INSTITUTE

Indiana University Medical Center, Indiana State Nurses Association, American Red Cross and the National Foundation for Infantile Paralysis are sponsoring a Polio Nursing Institute to be held in Indianapolis at the Medical Center, April 18 and 19. The purposes of this Institute are:

- 1) Alleviate nurses' fear of polio cases.
- 2) Teach nurses in the care of Respirator cases, and
- 3) Teach nurses in the use of the Hot Pack Machine, and the method of hot-packing the polio patient.

The first day of the Institute will be devoted to lectures and demonstrations, and the second day to put into practice the discussions of the first day—such as hot-packing the patient, actual floor work, et cetera.

The instructors for this course will consist of a member of the staff of The Medical Center, and one or two representatives from the Joint Orthopedic Nursing Advisory Service from New York.

This Institute is conducted principally for the instruction of nurses, but all the material to be presented will be of interest to physicians, and all doctors are invited and urged to attend.

MR. BRUNCHER IS A DONUT-MUNCHER

Skip breakfast? Not Bruncher.

Not if you consider coffee-and at 10 a.m.

as breakfast, that is. Of course, this kills his appetite for lunch, but he can always make that up by an afternoon visit to the cruller counter, which kills his appetite for dinner . . .

And thus does Bruncher meal-skimp his way to a subclinical vitamin deficiency.

Your own experience with these half-sick, half-well cases indicates that the first and wisest move is dietary reform. And isn't it also wise to prescribe, *additionally*, a vitamin supplement—to assure adequate intake just in case a patient strays from the prescribed diet?

For your prescribing convenience, there's an Abbott vitamin product to answer nearly every vitamin need—for supplementary or therapeutic levels of dosage, for oral or parenteral administration. All are rigidly standardized to conform with label listings.

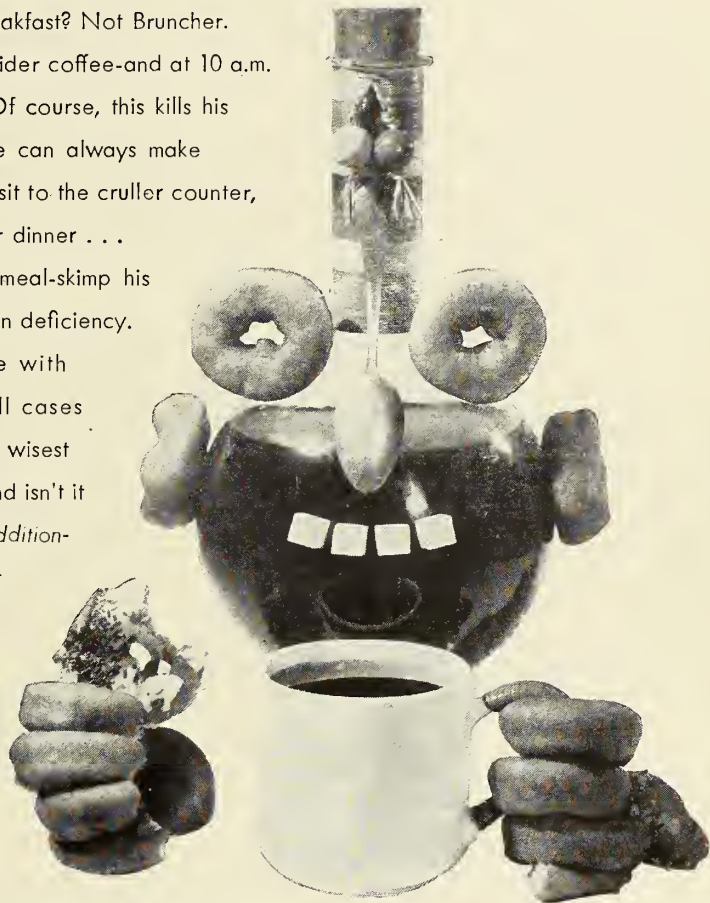
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Members of the medical profession are invited to attend the annual meeting of the **Indiana Tuberculosis Association and Indiana Trudeau Society** which will be held May 24 and 25 in Hotel Lincoln, Indianapolis.

The medical program is scheduled for May 25. Highlighting the morning session will be papers presented on antibiotics and the use of para-aminosalicylic acid in tuberculosis.

Dr. H. McLeod Riggins of New York City, past president of the American Trudeau Society, has been invited to speak on antibiotics. Dr. Henry C. Sweany, director of research, Municipal Tuberculosis Sanatorium, Chicago, and winner of the 1948 Dearholt Medal of the Mississippi Valley Conference on Tuberculosis, will present the paper on P.A.S. Also, in the morning, Dr. Louis W. Spolyar, of the Indiana State Board of Health, will speak on "Industrial Chest Diseases." Dr. O. T. Kidder of Fort Wayne, president of the Indiana Trudeau Society, will preside.

The joint session with the Indiana Tuberculosis Association that afternoon will feature a paper on new drugs and will include papers on "Evaluation of Primary Infection," by Dr. Raymond C. Meyer, superintendent and medical director, Hillcrest Tuberculosis Hospital, Vincennes, and "Management of the Tuberculous Individual," by Dr. Donald W. Brodie of Indianapolis.

PARK SCHOOL GARDEN TOUR

Eleven beautiful Indianapolis gardens will be included in the annual Park School Garden Tour, scheduled for Saturday and Sunday, May 7 and 8. They range in size from small backyard gardens to large estates. Among the gardens new to the tour this year are those of the Messrs. and Mesdames William W. Garstang, Louis J. Rybolt, Burke Nicholas and Kurt Pantzer. Gardens displayed again this year are those of Messrs. and Mesdames Theodore B. Griffith, Nicholas Noyes, Eli Lilly, John S. Wright, Julian Bobbs, Mrs. J. K. Lilly, and Dr. and Mrs. G. H. A. Clowes. Proceeds from the tour will go to the Park School Scholarship Fund. In other years the gardens have been enthusiastically inspected by many groups of garden lovers from throughout the state. Tickets may be ordered in advance from Mrs. Harold West, 4120 North Illinois Street, Indianapolis, or they may be purchased at any one of the display gardens on either day of the tour.

WARNING

The Federal Security Administration's Food and Drug Administration is making seizure of Syrup of Urethane. This is a cough syrup manufactured by Marvin R. Thompson, Inc., Stamford, Conn. Physicians, pharmacists, and consumers are warned that the administration of Urethane in the quantity recommended on the label may cause a dangerous lowering of the white blood cell count. This leaves the patient more liable to infection from disease germs. Individuals suffering from coughs are likely to have accompanying infections.

SEASICKNESS PREVENTIVE AND CURE

Working in conjunction with civilian investigators, the Army Medical Department has sponsored development of a new drug, "Dramamine," that acts as both a cure and preventive of seasickness or motion sickness.

Credit for the original research is given to Dr. Leslie N. Gay, of the Protein Clinic of Johns Hopkins University Hospital, Baltimore, Maryland, who first began research on the drug in 1947, and Dr. Paul Carliner, also of Johns Hopkins.

In experiments recently completed, almost total cure or prevention of seasickness, in all degrees of severity, was obtained among more than 400 passengers aboard an Army transport in heavy seas.

Both the preventive and curative values of the drug in relation to seasickness were investigated during the voyage. The physicians reported that of the men who received preventive treatment, less than 2 percent became seasick. In the therapeutic tests, the drug failed to give complete relief in only 3 percent of cases.

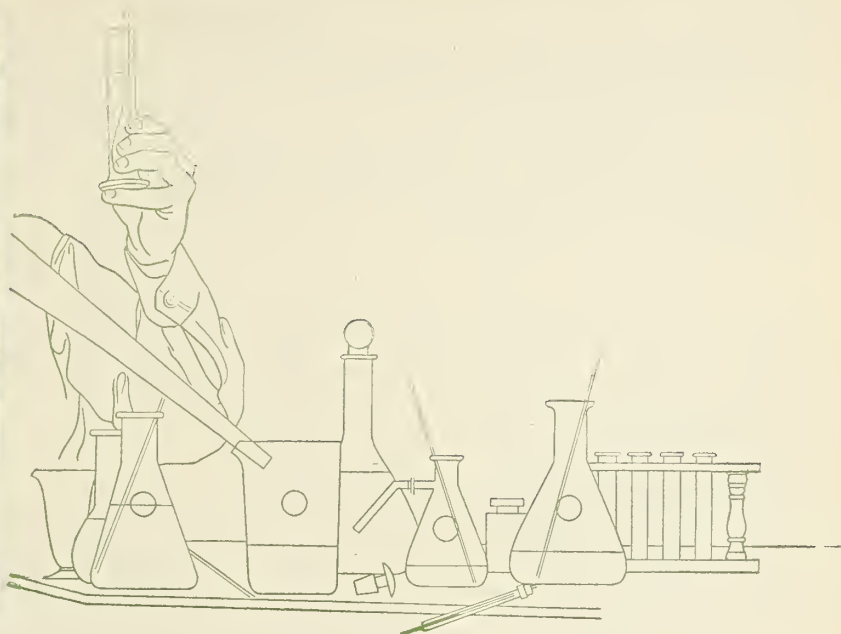
During the extremely rough voyage, a total of 418 cases, including relapses of moderate to violent seasickness, were treated with Dramamine. Complete relief was obtained in 407 cases, with partial relief or failure in 11 cases.

Careful observation was made for unpleasant symptoms, but in not one instance, even though thousands of capsules were administered to more than 300 men, was there a complaint or evidence of discomfort which necessitated discontinuance of treatment.

Seasickness has been an important military problem because of the frequent necessity of transporting great numbers of men by air or sea and landing them in excellent physical condition. Special attention was paid to the problem during World War II, in the course of which many drugs were used in an attempt to control its symptoms.

All previous remedies had been combinations of various drugs, such as scopolamine, one of the barbiturate preparations. Dramamine is a single chemical which is believed to have a direct effect on the vomiting center in the brain. It is a member of the chemical family of benadryl and pyribenzamine, which are used in the treatment of certain allergic conditions. The complete chemical name is beta-diaminoethyl benzohydryl ether 8-chlorotheophyllinate.

Future plans call for broadening of experiments with Dramamine to include such means of travel as landing craft, small boats, and aircraft.



Dorsey

REFINING THE TOOLS TO DO THE JOB

While medical men are occupied with enlarging their knowledge of disease and treating its manifestations, the makers of ethical drugs concentrate on developing and improving the "tools" to facilitate treatment.

Toward that end, the Smith-Dorsey Company has expanded its research facilities, secured increased research grants and added research personnel.

Our objective — tools worthy of *the finest* workman . . .

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Deaths

Luther A. Mott, M.D., of Elwood, died at Elwood on February 7, after a long illness. He was seventy-seven years of age. He graduated from the Pulte Medical College of Cincinnati, in 1900, and had practiced in Elwood since 1901.

* * *

Albert August Watts, M.D., of Gary, died suddenly in his home on February 18. He was sixty-one years of age. He graduated from the Chicago College of Medicine and Surgery in 1915, and began his practice in Gary in 1916. Doctor Watts was a veteran of World War I, in which he served with the rank of captain, attached to a British regiment. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

William S. Workman, M.D., former Orleans physician, died in Indianapolis on February 13, at the age of ninety-two. A graduate of the Louisville Medical College in 1891, Doctor Workman had practiced in Mitchell, Livonia and Orleans, until he retired five years ago and moved to Indianapolis. He formerly was an Honorary member of the Orange County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

* * *

Ellis Hall Tade, M.D., of Bicknell, died on February 24, after a long illness. He was seventy years of age. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1905, and had practiced in Bicknell for thirty-three years. Prior to that he had practiced medicine in Wheatland.

* * *

Bowen Carr Bowell, M.D. formerly of LaPorte, died on March 2, after an illness of two months. He was seventy-nine years of age, and had practiced medicine and surgery for fifty years, forty years of which were spent in LaPorte. He was a graduate of the University of Illinois College of Medicine, in Chicago, in 1895.

Edward Gustine Blinks, M.D., retired physician of Michigan City, died on February 11, after a long illness. He was eighty years of age, and he had practiced in Michigan City for more than fifty years, prior to his retirement two years ago. He graduated from the Worcester Medical College of Worcester, Massachusetts, in 1893, and began practicing in that year. He was an honorary member of the LaPorte County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

* * *

Raymond Alfred Butler, M.D., of Beech Grove, died on February 25, his sixty-fourth birthday. He was a graduate of Indiana University School of Medicine, in 1908, and he had practiced in Beech Grove since 1913, specializing in Surgery. He was a veteran of World War I, when he served overseas with Ambulance Company 26, 3rd Division. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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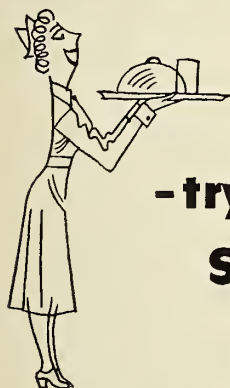
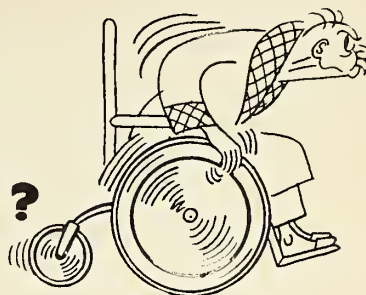
Ralph Moody Funkhouser, M.D., of Indianapolis, died on February 27, at the age of sixty-four. He was a graduate of Indiana University School of Medicine, in 1912, and served as a captain in World War I. Following this, he was a member of the neuropsychiatric staff of the Veterans Administration in Indiana and Illinois. For the past five years he had been on the staff of the Veterans Administration Hospital in Chicago.

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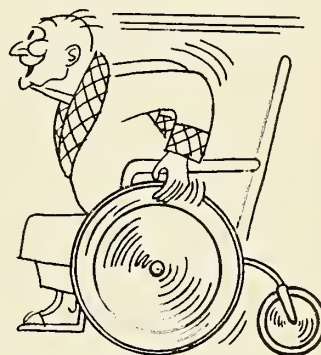
Joseph H. Kinsey, M.D., who had practiced in Richmond for more than sixty years, died on February 14, at the age of eighty-two. A graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1888, he established practice in Richmond that same year. Doctor Kinsey was a member of the Wayne-Union County Medical Society, the Indiana State Medical Association, and the American Medical Association.



Sick folks sick of soft diets?



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veal, liver, heart

The foods soft-diet patients have to eat! No wonder they succumb to appetite-apathy.

But many physicians today have discovered there is a way to put appetizing, real meat goodness into soft diets. They recommend Swift's Strained Meats. These specially prepared meats retain all their palatability, and a maximum of nutrient value in a form that's highly digestible—easy to eat. To vary patients' menus, Swift's Strained Meats offer six different

varieties. Convenient—ready to serve.

Nutritionally, Swift's Strained Meats provide an excellent base for a high-protein, low-residue diet. A rich source of complete, high-quality proteins, they make available simultaneously all known essential amino acids—for optimum protein synthesis. In addition, Swift's Strained Meats supply hemapoeitic iron and goodly amounts of B vitamins. Let Swift's Strained Meats help overcome anorexia in your soft-diet patients!

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All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.



For patients who can take foods of less fine consistency—Swift's Diced Meats offer tender morsels of nutritious meats with tempting flavors patients appreciate.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

February 20, 1949.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Walter L. Portteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Albert Stump, attorney; Ray E. Smith, executive secretary; Larry Richardson, field secretary.

Guests: J. William Wright, M.D., and Don E. Wood, M.D., co-chairmen, Legislative Committee; Marshall I. Hewitt, M.D., chairman, Committee on Diabetes; Cleon A. Nafe, M.D., A.M.A. Planning Committee.

Membership Report

Number of members January 31, 1949-----	2,595*
Number of members January 31, 1948-----	2,568
Gain over last year -----	27
Number of members December 31, 1948-----	3,685

*Includes 136 honorary members
23 in military service

Statements of receipts and expenditures for January for the association and THE JOURNAL were approved.

1949 Annual Session, Indianapolis, September 26-29, 1949

Dr. Hauss reported on progress of plans for the centennial meeting.

Meeting of Indiana Academy of General Practice. On motion of Drs. Ellison and Black, the executive secretary was directed to write to the Indiana Academy of General Practice and suggest that instead of a dinner on Wednesday night, September 28, the group hold a luncheon on that date, and that if it so desires, the afternoon scientific program will be scheduled for a later hour than usual for its convenience.

Technical exhibit.

a. On motion of Drs. Portteus and Ellison, the president and executive secretary were authorized to work out a floor plan and rental prices for space.

b. It was taken by consent that nonmedical business houses should be invited to exhibit at the centennial session.

Legislative Matters

National

A.M.A. educational campaign.

a. Dr. Cleon A. Nafe, Indiana member of the Committee of Fifty-Three of the A.M.A., gave a comprehensive report on the A.M.A. educational campaign as revealed by Whitaker and Baxter at Chicago on February 12.

b. The executive secretary reported on the refusal of some members of the Clay County Medical Society to pay the A.M.A. assessment and the vote of the Ripley County Medical Society against paying this assessment. The secretary said the matter had been called to the attention of the councilors of the districts in which these societies are located.

Educational program in Indiana.

a. Drs. Black and Ellison moved that the committee already appointed be authorized and given power to take whatever steps it deems necessary to make the A.M.A. national educational campaign function at the state level. (Members of this committee are Drs. McCaskey, Portteus, Nafe, Hauss and Dodds.) Drs. Hauss and Black moved that the committee report its progress to the Executive Committee at its next meeting.

b. On motion of Drs. Hauss and Ellison, it was recommended to the Council that \$1,000 a month, for a period not to exceed three months, be appropriated for financing the Indiana activities, and that the councilors be polled by mail for their approval of this recommendation.

c. The committee voted that the Indiana State Medical Association bear all additional expense incident to the collection of the A.M.A. assessment. The bill for the printing of collection receipt books already has been paid by the A.M.A.

Physicians for military service. Letter received from the Tennessee State Medical Association revealing its action in urging physicians educated under the ASTP to volunteer for military service was referred to the Committee on Veterans Affairs.

Local

The co-chairmen of the Committee on Public Policy and Legislation reported on the status of legislation of interest to the medical profession in the 1949 General Assembly.

S. B. 78. On motion of Drs. Portteus and Hauss, the Executive Committee reaffirmed its support of S. B. 78, and the physician member of the Senate and the members of the Indiana Advisory Health Council are to be notified of this action.

Organization Matters

The field secretary read a report of his activities since his employment on December 1, 1948. Action upon the future program of the field secretary was deferred until the next meeting of the Executive Committee.

The president outlined his plan to appoint a committee to study medical fee schedules and provisions of employer-financed health protection, collective bargaining, and other cooperative health plans, in order to protect the interests of the private physicians of Indiana and to promote fair and ethical physician-patient relationship for all involved.

On motion of Drs. Black and Portteus, the appointment of a committee to study industrial and cooperative medical care programs was approved.

The chairman of the Committee on Diabetes of the Indiana State Medical Association told of the plans of his committee to make a diabetes survey in October by asking each county medical society to appoint a Diabetes Survey Committee for this purpose. On motion of Drs. Portteus and Ellison, the committee voted approval of this project of the Committee on Diabetes.

Election of members of Board of Directors, Mutual Medical Insurance, Inc. Mr. Stump called attention to the fact that the terms of the following five members of the Board of Directors of Mutual Medical Insurance, Inc., will expire soon: Drs. Wemple Dodds, A. F. Weyerbacher, Alfred Ellison, C. J. Clark, and Charles Overpeck. The Executive Committee is to recommend their re-election or successors at its next meeting.

Veterans' Affairs

The Veterans Committee presented a letter to be sent to the county medical societies asking them to encourage young men educated under the ASTP program to volunteer for military service. Indiana has 162 doctors under 26 who did not reply to a letter sent to them by the president of the American Medical Association. On motion of Drs. Hauss and Ellison, the suggested letter was ordered sent.

The Journal*Report on advertising:*

Increase in February -----\$726.00
Decrease ----- 255.00

Total increase, February -----\$471.00

Total increase for year-----\$943.00

There being no further business, the committee adjourned to meet again at 9:30 a. m., Sunday, March 13, 1949, at the Columbia Club.

EXECUTIVE COMMITTEE

March 13, 1949

Roll call showed the following present: C. H. McCaskey, M.D.; Walter L. Porteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith, executive secretary; Larry Richardson, field secretary.

Guest: Cleon A. Nafe, M.D., A.M.A. Planning Committee.

On motion of Drs. Porteus and Black, Dr. McCaskey was re-elected chairman of the Executive Committee for 1949.

Membership Report

Number of members February 28, 1949..... 3,273*

Number of members February 28, 1948..... 3,324

Loss over last year..... 51

* Includes 158 honorary members

24 in military service

Number of members December 31, 1948..... 3,685

Treasurer's Office

The treasurer explained that the statement for auditing the books for 1948, which was approved for payment at the February 20 meeting of the committee, was \$170.45 as against \$125.50 for the 1947 audit, because the George S. Olive and Company had increased its daily rate from \$30.00 to \$40.00 in 1948.

Future Medical Meetings

Attention of the committee was called to district meetings which have been scheduled as follows:

April 5, 1949—Twelfth District, Fort Wayne

May 4, 1949—Sixth District, New Castle

May 10, 1949—Seventh District, Indianapolis

May 18, 1949—Eleventh District, Logansport

May 25, 1949—Third District, Corydon

May 25, 1949—Fourth District, Aurora

May 25, 1949—Ninth District, Tipton

Nov. 9, 1949—Thirteenth District, South Bend

Statements of receipts and expenditures for February for the association and THE JOURNAL were approved.

1949 Annual Session, Indianapolis,

September 26-29, 1949

Program.

a. Preliminary draft of the program was reviewed by the committee.

b. *Motion pictures and television.* The president reported that the present plan is to have motion pictures and television run continuously from 9:00 to 4:00 p.m.

on September 27, 28 and 29. The question of whether the visual program should operate in conflict with the scientific speaking program is to be discussed with the Committee on Scientific Work and the Committee on Centennial Arrangements.

c. *Luncheon meeting of Indiana Academy of General Practice.* Letter from the secretary of the Indiana Academy of General Practice, requesting that no other organizations be permitted to hold luncheons on Wednesday, September 28, 1949, in competition with the Academy's luncheon, was read, and on motion of Drs. Porteus and Hauss, the executive secretary was directed to write the Indiana Academy of General Practice that the association will not sponsor any luncheon or counter-attraction at this time.

Legislative Matters*National*

National Community Health Institute, Cincinnati, April 7, 1949. The president, chairman of the A.M.A. Campaign Coordinating Committee, and the executive secretary were authorized to attend the National Community Health Institute, sponsored by the Chamber of Commerce of the United States, to be held at the Netherland Plaza Hotel, Cincinnati, April 7, 1949.

A.M.A. national education campaign. Following a report by Dr. Nafe, chairman of the A.M.A. Campaign Coordinating Committee, and the Indiana member of the A.M.A. "Committee of Fifty-Three," on the Indiana phase of the campaign, including a proposed budget of almost \$30,000.00, it was voted, by motion of Drs. Hauss and Porteus, that the financial condition of the association should be called to the attention of the Council at its meeting on April 10, and that it be recommended to the Council that \$20,000.00 be appropriated from the general fund of the association to finance the Indiana campaign for the balance of 1949. This motion also included the recommendation to the Council that it propose to the House of Delegates that the state association dues be increased by from \$5.00 to \$10.00 beginning in 1950.

The executive secretary reported that the Council had voted by mail in February to make \$3,000.00 available out of the general fund for the Indiana campaign.

Upon the suggestion of the Executive Committee the president appointed an A.M.A. Campaign Coordinating Committee to be in charge of the A.M.A. national health education campaign in Indiana. The members of this committee are: Drs. Nafe, chairman; McCaskey, Porteus and Dodds.

Report was made that 1,432 members had paid their assessment as of March 11.

Local

The executive secretary gave a brief review of legislation affecting medicine passed by the 86th Indiana General Assembly.

Organization Matters

1949 budget. The chairman of the Budget Committee called attention to the 1949 budget.

United States Pharmacopoeial Convention, Washington, D.C., May 9 and 10, 1950. The president reported that he is appointing Dr. R. A. Solomon of Indianapolis as Indiana's delegate to the United States Pharmacopoeial Convention to be held in Washington, May 9 and 10, 1950.

The field secretary submitted a report on his visits to three county medical societies and made certain recommendations. It was taken by consent that the recommendations would not be acted upon until the next meeting of the committee.

After a discussion of reports that private insurance representatives are objecting to physicians promoting hospital and pre-paid medical care plans which they charge is in competition with private insurance com-

panies, Dr. Portteus was asked to investigate whether it is possible for local insurance men to participate in the Blue Cross-Blue Shield programs.

On motion of Drs. Portteus and Hauss the following five physicians were recommended to the Board of Directors of Mutual Medical Insurance, Inc., for consideration as members of the Board: Drs. Wemple Dodds, Crawfordsville; A. F. Weyerbacher, Indianapolis; C. J. Clark, Indianapolis; Charles F. Overpeck, Greensburg, and G. O. Larson, La Porte.

Mental health clinics. Dr. Portteus, chairman of the Council on Mental Health, reported that the federal government is offering \$50,000.00 to Indiana to help finance psychiatric clinics to be operated under sponsorship of the Council on Mental Health. The clinics will be established only after approval of the county medical societies. On motion of Drs. Hauss and Black, a decision for or against the acceptance of federal funds was left to the Committee on Mental Health of the state medical association and the chairman of the Council on Mental Health.

A physician reported that the director of the Bureau of Laboratories of the Indiana State Board of Health was sending reports of brucellosis tests to private patients and apparently was presuming diagnoses from these reports. On motion of Drs. Hauss and Black, the executive secretary was directed to take up the matter with the state health commissioner.

Submission of Dr. D. D. Oak's name to A.M.A. for "1949 Family Doctor of the Year Award." Letter received from a friend of Dr. D. D. Oak of La Crosse, suggesting that the state association submit the name of Dr. Oak to the American Medical Association again this year for the "Family Doctor of the Year Award," was read. The committee directed the executive secretary to point out, in reply to this letter, that the association cannot do this because it is compelled, by A.M.A. rules, to submit the names of the physicians selected each year for the "Indiana General Practitioner of the Year Award."

The request of the commercial representative of Western Union Telegraph Company office in Indianapolis that the association write letters to certain senators and congressmen, asking for a reduction in excise taxes, was brought to the attention of the Executive Committee. It was taken by consent that the association comply with this request if such action is approved by the Indiana State Chamber of Commerce.

The Journal

Report on advertising:

Increase in March-----\$ 704.70
(no decrease)

Total increase for year-----\$1,637.70

The committee turned down the request of Lyman A. Massey, advertising representative, who submitted copy for sale of cigarettes by mail, which would be an act to avoid state cigarette tax.

Advertising copy submitted by Mutual Benefit of Omaha was discussed by the legal counsel. It was taken by consent that he should change the copy and submit it to the company for approval before the advertising is accepted.

There being no further business, the committee adjourned, to meet again at 6:30 p.m., Saturday, April 9, 1949, at the Columbia Club.

COMMITTEE ON PUBLICITY

February 8, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Larry Richardson, field secretary, and Ray E. Smith, executive secretary.

The following "Hints on Health" columns were approved:

Week of March 21, 1949—"Time for Inventory."

Week of March 28, 1949—"Oh, What's the Use?"

Letter from Mrs. Betty L. Wagoner of Delphi was read, telling of the successful talk on socialized medicine by the chairman of the Legislative Committee of the state Woman's Auxiliary before the Woman's Club at Delphi.

The committee voted to send Hamilton A. Long, of Chicago, a list of county medical society secretaries and let him offer them copies of his pamphlet, "You . . . and Patrick Henry . . . and Your Liberty Today," instead of the committee mailing samples.

Speakers procured:

February 15, 1949—Knox County Medical Society, Vincennes. "Compulsory Sickness Insurance Legislation," field secretary.

The executive secretary discussed chiropractic legislation pending in the Indiana General Assembly.

February 25, 1949

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and Larry Richardson, field secretary.

Minutes of the meeting of February 8, 1949, were approved.

A "Hints on Health" article on "Gout" received the approval of the committee.

Speakers procured:

February 23, 1949—Purdue University Extension Forum, Indianapolis. "Socialized Medicine," attorney of state medical association.

February 24, 1949—Chamber of Commerce, New Castle. "Socialized Medicine," field secretary.

February 28, 1949—Business and Professional Woman's Club, Delphi. "Socialized Medicine," executive secretary.

March 1, 1949—Orange County Medical Society, West Baden. "The A.M.A. Program and Socialized Medicine," field secretary.

March 9, 1949—Public meeting, Kokomo. "Socialized Medicine," field secretary.

March 11, 1949—Putnam County Medical Society, Greencastle. "The A.M.A. Program and Socialized Medicine," field secretary.

March 16, 1949—Kiwanis Club, Connersville. "Compulsory Sickness Insurance," attorney of state medical association.

By unanimous vote the committee authorized the secretary to purchase 136 copies of the book by Lawrence Sullivan, "The Case Against Socialized Medicine." One copy will be sent to each of the 83 county medical society secretaries, 23 copies will be sent to selected college libraries in Indiana, 25 copies will be held in reserve in the state medical association office, and five copies were ordered for the personal use of Dr. Ritchey, chairman of the committee.

The committee unanimously agreed to supply Congressman Ralph Harvey with 125 packets of Margaret Shearon's material against socialized medicine after considering a request from the Congressman for the booklets. The congressman's letter indicated that his office is receiving requests for such material from constituents. Mimeographed material from the state medical headquarters office will also be sent.

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COUNCILOR DISTRICT MEETING

TENTH DISTRICT

The Tenth District Medical Society met at Tiebel's Restaurant in Schererville on March 10, and heard an excellent paper on peptic ulcer by Dr. A. C. Ivy of Chicago, vice-president of the University of Illinois College of Medicine.

Others who spoke were Dr. William H. Howard of Hammond, councilor; Dr. J. R. Doty of Gary, a member of the Committee on Public Policy and Legislation of the Indiana State Medical Association, and Ray E. Smith, executive secretary of the state association.

Dr. Paul C. F. Vietzke of Valparaiso, district president, presided.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

CARROLL COUNTY MEDICAL SOCIETY

President, Hubert Gros, Delphi,
Vice-President, George Wagoner, Delphi,
Secretary-Treasurer, Thomas C. Brown, Delphi.

DECATUR COUNTY MEDICAL SOCIETY

President, Boyd L. Mahuron, Greensburg,
Vice-President, E. A. Porter, Westport,
Secretary-Treasurer, James C. Miller, Greensburg.

MARSHALL COUNTY MEDICAL SOCIETY

President, Otis R. Bowen, Bremen,
Vice-President, Vactor O. Connell, Bourbon,
Secretary-Treasurer, L. W. Vore, Plymouth.

PIKE COUNTY MEDICAL SOCIETY

President, Milton Omstead, Petersburg,
Vice-President, John King, Petersburg,
Secretary-Treasurer, Richard R. Fowler, Petersburg.

SCOTT COUNTY MEDICAL SOCIETY

President, Carl Bogardus, Austin,
Vice-President, T. N. Hill, Scottsburg,
Secretary-Treasurer, Floyd S. Napper, Scottsburg.

SHELBY COUNTY MEDICAL SOCIETY

President, R. W. Gehres, Shelbyville,
Vice-President, D. B. Silbert, Shelbyville,
Secretary-Treasurer, W. M. Wiley, Shelbyville.

Boone County Medical Society members held a meeting on January 4 at the Witham Hospital, at Lebanon. This was a business meeting, with fourteen members in attendance.

Another meeting was held there on February 1, when seventeen members were present, for a discussion of proposed hospital staff rules.

Dubois County Medical Society members held a meeting in Jasper on February 10, when Dr. Earl H. Antes, of Evansville, was the guest speaker. His subject was "The Diagnosis and Management of Congestive Heart Failure."

Fountain-Warren Medical Society members held a meeting on February 3, at the Mudlavia Hotel, in Attica. Nine members were present.

Grant County Medical Society members held a meeting on January 27 at the Marion General Hospital in Marion. The guest speaker was Dr. Harry Baum, of Indianapolis, who spoke on "The Diagnosis and Treatment of Common Cardiac Arrhythmias."

Gibson County Medical Society members held a meeting at the Hotel Emerson, in Princeton, on February 14. Seventeen members were present, to hear Dr. Stephen L. Johnson, of Evansville, speak on "Office Cardiacs."

Hendricks County Medical Society members held a meeting on February 9, when Dr. Robert Dearmin, of Indianapolis, spoke on "Ear, Nose and Throat and the General Practitioner." Eleven members were present.

Howard County Medical Society members held a meeting on February 4 in Kokomo. A Blue Cross community enrollment plan for Kokomo was discussed, and the plan was indorsed by the society. Twenty-four members were present.

Lake County Medical Society members held a meeting at the Indiana University extension in Gary on February 10. Guest speakers were Dr. Edward C. Holmblad, of Chicago, whose subject was "Alcoholism in Industry"; and Dr. David Slight, of Chicago, who discussed "Alcoholism, General and Psychiatric Aspects." A representative of Alcoholics Anonymous also appeared on the program.

Montgomery County Medical Society members held a meeting at Culver Hospital, in Crawfordsville, on January 20. Dr. Clyde G. Culbertson, of Indianapolis, spoke on "Some Newer Aspects Relative to Immunity." Twenty-nine members were present.

Another meeting was held on February 17, when Dr. Wemple Dodds, of Crawfordsville, discussed compulsory health insurance. Twenty-four members were present at this meeting.

Morgan County Medical Society members held a meeting in Morgan County Memorial Hospital in Martinsville on February 2. Twelve members were present, to hear Dr. K. E. Comer, of Mooresville, discuss "Office Proctology."

At another meeting, on March 2, Dr. M. G. Murphy, of Morgantown, was the speaker. He spoke on "Experiences in Forty Years of Country Practice." Ten members were present.

Orange County Medical Society members met at West Baden Springs on February 1, when plans were made for community enrollment of Orleans County in the Blue Cross. Seven members were present.

Another meeting was held on March 1, when Mr. Larry Richardson, field secretary of the state association, spoke on "Socialized Medicine." Seven members were present at this meeting.

Parke-Vermillion County Medical Society members held a meeting at the Vermillion County Hospital in Clinton on January 19. Eleven members were present to hear Mr. Joseph Sharron and Mr. D. T. Jackson, of Indianapolis, discuss the Blue Cross—Blue Shield Plan.

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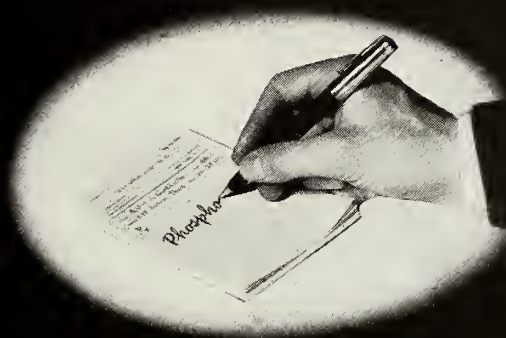
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Putnam County Medical Society members held a meeting on February 11, to hear Mr. John Claycombe and Mr. Ray Urbain discuss "Community Enrollment in Blue Cross." Sixteen members were present, and voted to enroll in Blue Cross as a group.

Shelby County Medical Society members met in Shelbyville on February 9, when Dr. David L. Adler, of Columbus, discussed the Papanicolaou Technique of Smears. Seventeen members were present.

St. Joseph County Medical Society members met at the Indiana Club in South Bend on February 8. Dr. Carl J. Rudolph, of South Bend, spoke on "Angiospasm," and Dr. John M. Thompson, of South Bend, spoke on "Some Eye Diseases in Relation to General Practice."

Tippecanoe County Medical Society members held a clinic for the physicians and the public at St. Elizabeth Hospital in LaFayette in the afternoon on February 8, which was attended by approximately two hundred persons. In the evening the doctors met at Lincoln Lodge, to hear Dr. Meyer A. Perlstein, of the Northwestern University of Chicago, discuss "Cerebral Palsies in Children." A physiotherapist accompanied Dr. Perlstein, and assisted in presentation of cases. Seventy members were present at this meeting.

Wabash County Medical Society members met at the Wabash Country Club on February 16. The sixteen members present heard representatives of Blue Cross—Blue Shield discuss community enrollment.

Whitley County Medical Society held a meeting in Columbia City on February 8. Dr. A. N. Ferguson, of Fort Wayne, was the guest speaker. His subject was "Common Arrhythmias of the Heart."

HOWARD COUNTY FIRST OVER THE TOP!

The Howard County Medical Society, which embraces Kokomo, is the first society in the state whose members have paid the American Medical Association \$25 assessment 100 per cent.

Dr. T. M. Conley, the secretary, collected the assessment from all thirty-nine regular members.

Congratulations to Doctor Conley and members of the Howard County Medical Society!

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. William Morrison, Kokomo.

President-elect—Mrs. Truman Caylor, Bluffton.

Corresponding Secretary—Mrs. Charles Viney, Logansport.

Recording Secretary—Mrs. Henry Bopp, Terre Haute.

Treasurer—Mrs. Wendell Kelly, Anderson.

Press and Publicity—Mrs. F. M. Gastineau, Indianapolis.

OUR GOAL

"Every Physician's Wife An Auxiliary Member"

PROGRAM

MEETING OF HOUSE OF DELEGATES

Woman's Auxiliary to the Indiana State Medical Association

Tuesday April 26

2:00 P.M. Board Meeting.

4:00 P.M. President's Musical Tea.

Hostesses: Huntington and Howard County Auxiliaries.

6:30 P.M. Dinner for all members of House of Delegates.

Wednesday, April 27

Business Session of House of Delegates.

9:00 A.M. Registration.

9:30 A.M. Call to order.

12:30 P.M. Luncheon.

2:00 P.M. Unfinished and new business.

3:30 P.M. Post-House of Delegate's Board Meeting.

MEMBERSHIP IN HOUSE OF DELEGATES

State officers and chairmen, presidents and presidents-elect of county auxiliaries are members of the executive board and the House of Delegates.

In addition to the above, each county auxiliary is allowed one delegate for every 25 members or fraction thereof, based on the membership filed with the state treasurer by March 31.

All meetings are to be held at the LaFontaine Hotel, Huntington.

In just a few more months the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, New Jersey, for their annual convention, June 6 to 10, 1949. Have you made your reservations? If not, send your request **at once** to Dr. Robert A. Bradley, chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

BOOKS RECEIVED

CLINICAL CASE-TAKING. By George R. Herrmann, M.D., professor of Medicine, University of Texas. Fourth Edition. 240 pages, with eight illustrations. Cloth. Price \$3.50. The C. V. Mosby Co., St. Louis, 1949.

DOCTORS OF INFAMY. The Story of the Nazi Medical Crimes. By Alexander Mitscherlich, M.D., head of the German Medical Commission to Military Tribunal No. 1, Nuremberg, and Fred Mielke. 172 pages, with 16 pages of photographs. Cloth. Price \$3.00. Henry Schuman, Inc., Publishers, New York, 1949.

PRACTICAL ASPECTS OF THYROID DISEASE. By George Crile, Jr., M.D., Department of Surgery, Cleveland Clinic. 355 pages with 101 figures. Cloth. Price \$6.00. W. B. Saunders Company, Philadelphia and London, 1949.

THE PSYCHOANALYTIC READER. An Anthology of Essential Papers with Critical Introductions. Edited by Robert Fliess, M.D. 392 pages. Cloth. Price \$7.50. International Universities Press, Inc., New York, 1949.

HANDBOOK OF DISEASES OF THE SKIN. By Richard L. Sutton, M.D., Emeritus Professor of Dermatology and Syphilology, University of Kansas Medical School; and Richard L. Sutton, Jr., M.D., Associate Professor of Dermatology and Syphilology, University of Kansas Medical School. 749 pages, with 1,057 illustrations. Cloth. Price \$12.50. The C. V. Mosby Company, St. Louis, 1949.

ATLAS OF PERIPHERAL NERVE INJURIES. By William R. Lyons, Ph.D., Associate Professor of Anatomy, University of California Medical School; and Barnes Woodhall, M.D., Professor of Neurosurgery, Duke Medical School, Durham, N. C. 339 pages. Cloth. Price \$16.00. W. B. Saunders Co., Philadelphia and London, 1949.

CURRENT THERAPY 1949—Latest Approved Methods of Treatment for the Practicing Physician. By Howard F. Conn, M.D., Editor. 672 pages. Cloth. Price \$10.00. W. B. Saunders Co., Philadelphia and London, 1949.

The Case Against Socialized Medicine

By LAWRENCE SULLIVAN

- This book tells the story of Socialized Medicine in easy, non-technical language. It exposes the government propaganda machine in Washington. It tells what happens to medical and hospital services when the citizen loses the right to select his own doctor.
- Socialized Medicine would add a million full-time payrollers to the federal budget . . . would create a U. S. medical bureaucracy twice the size of the Post Office Department. Doctors would be appointed like postmasters.



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BOOKS REVIEWED

THE CASE AGAINST SOCIALIZED MEDICINE. By Lawrence Sullivan, Washington, D. C. 53 Pages. Cloth. Price \$1.50. The Statesman Press, Washington 4, D. C., 1948.

With an enthusiastic congress feeling that they have "an ultimatum from the people" to formulate legislation to enforce compulsory health insurance on the American people, it behooves the medical profession to inform the people of the real facts of the case. "The Case Against Socialized Medicine" contains these facts, carefully condensed into a few pages of comprehensive and telling facts which everyone should know. The medical profession must know them so that they can give the **reasons**; not just vague opinions—but factual reasons why socialized medicine is not the way to solve the health problems of the American people. This book is not an argument "for and against," it is all **against**. It is **just what** it says, "The Case Against Socialized Medicine," a case that **everyone**, **EVERYONE** should have clearly in mind, arranged in a manner which makes it easy to remember and easy to read in from 15 to 30 minutes, depending on whether you are a fast or **very** slow reader.

Every physician should have a copy on his waiting room table, and every doctor's wife should have one to help her discuss socialized medicine at her next Bridge Club meeting. This book has just the right amount of stuff in it for a service club luncheon talk, or an editorial in the local paper. County medical societies should place copies of this book in all public libraries and school libraries.

One of the fine things about this book is that it is written by a layman, and a layman who is a well known national figure in the journalistic field.

Lall G. Montgomery, M.D.

A PRIMER OF CARDIOLOGY. By George E. Burch, M. D., Associate Professor of Medicine, Tulane University School of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans, and Paul Reaser, M.D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. 272 pages with 203 illustrations. Cloth. Price \$4.50. Lea & Febiger, Philadelphia, 1947.

With the thought in mind of writing a primer for medical students and beginners in cardiology, the authors have produced a book of value to the experienced cardiologist as well.

The authors begin their book with anatomic facts that must be known in the study of cardiology. They then stress the necessity of approaching in an organized fashion the diagnosis of heart disease so that it is a thorough and careful study of the patients ailment.

Because the authors did not intend for the primer to be encyclopedic, they have not discussed all of the forms of heart disease, but instead they have emphasized the most common ones.

In bedside diagnosis of cardiac irregularities the authors feel that the electrocardiograph is of extreme importance but that the physician should obtain as much information as possible by observation of simple phenomena and that the clinician should be able to evaluate the patient without the help of any precise instruments. This is covered very thoroughly.

The illustrations are of invaluable assistance in the study of cardiology.

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1. The protein of this delicious food drink—Ovaltine in milk—is of high biologic value, supplies all the indispensable amino acids required for tissue maintenance and growth and other physiologic needs.

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CLINICAL ASPECTS AND TREATMENT OF SURGICAL INFECTIONS. By Frank Lamont Meleney, M.D., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University, Associate Visiting Surgeon, Presbyterian Hospital, New York City. 840 pages, with 287 figures. Fabrikoid. Price \$12.00. W. B. Saunders Company, Philadelphia and London, 1949.

Those who lament the literary mediocrity of medical books and papers should read, or at least browse in this book. They will find the pasture fresh, green, succulent and full of protein. Moreover, it will soon become apparent that the author is not only a scholar in his field but that he has had large practical experience at bedside and operating table. The case histories are presented so clearly, so succinctly and in such a conversational style that the reader feels he is attending ward rounds from his easy chair.

The bibliography and review of literature are well done and presented in such a way that they do not intrude upon the author's own contributions. The index has a convenient feature, in that the subject matter is all in lower case while the names of authors referred to in text or bibliography are in upper case. The typography is easy on the eyes throughout.

The subject matter is treated systematically by areas, organs and tissues, each topic being analyzed as to pathogenesis, bacteriology, symptoms, signs, and treatment, in that order. Then follow illustrative cases, many with plates and diagrams.

Many chapters have an introduction which is a model of concise and scholarly medical history, such as, for instance, that for Chapter X on Surgical Infections of the Appendix. By judicious quotations from men who did the pioneer research and took the first steps toward rational treatment, Dr. Meleney leaves the reader with a great regard for early surgeons and also a healthy respect for infections of the vermiform appendix. He then shows by means of illustrative cases the various disguises appendicitis can assume and the numerous complications. Included in all cases, throughout the book, are history, physical examination, and course, the latter including treatment and the bacteriological involution, or evolution.

The thoroughness of this work is exemplified by the chapter on bones and joints where treatment of osteomyelitis is described in detail, including methods before World War I, then Carrel-Dakin, Orr, bacteriophage, sulfonamide, penicillin, bacitracin, and streptomycin treatments. There is a discussion of the cases of acute hematogenous osteomyelitis and another discussion of the chronic cases.

As its title suggests, the clinical side is emphasized in this book. The more technological aspects of this field, especially the research and bacteriological techniques, are fully covered in a recent treatise on surgical infections by the same author, published by the Oxford Press. In our opinion, "Clinical Aspects and Treatment of Surgical Infections" should be of great value to student, surgeon, and general practitioner.

A.W.C.

MAYO CLINIC DIET MANUAL. By the Committee on Dietetics of the Mayo Clinic. 329 pages. Price \$4.00. Philadelphia: W. B. Saunders and Company, 1949.

A manual published for the guidance of physicians, nurses and dietitians in planning diets. Charts used are easily understood. Diets are tabulated as to:

- (1) proportion of carbohydrate, protein and fat
- (2) foods included and excluded
- (3) dietary pattern and sample menus.

The appendix contains much useful information regarding composition of food, height-weight tables and a nomograph for calculation of caloric needs. The book fulfills its purpose very well. It will be helpful in the teaching of dietetics.

HUMAN BIOCHEMISTRY. By Israel S. Kleiner, Ph.D., Professor of Biochemistry and Director of the Department of Physiology and Biochemistry, New York Medical College, New York. Cloth. Price, \$7.00. Pp. 649, with 77 text illustrations and 5 color plates. Second edition. The C. V. Mosby Company, St. Louis. 1948.

This textbook presents the subject of biochemistry in a most readable manner. The topics of discussion are well developed and the clinical aspects integrated within the text in a very understandable manner. The subject matter is up-to-date with the recent trends. References to both textbooks and original references appear at the end of each chapter. Illustrations, charts, diagrams, and tables are abundant and easily interpreted. Chapters on Chemical Structure in Relation to Biological Phenomena, and Recent Clinical Applications are included.

This textbook should be welcomed by the student, advanced worker, instructor, or busy clinician who needs a most readable text for a ready reference.

PREOPERATIVE AND POSTOPERATIVE CARE OF SURGICAL PATIENTS. By Hugh C. Ilgenfritz, M.D., formerly Assistant Professor of Surgery, Louisiana State University School of Medicine, and Visiting Surgeon, Charity Hospital of Louisiana, New Orleans. 898 pages, with 110 illustrations. Cloth. Price \$10.00. The C. V. Mosby Co., St. Louis, 1948.

Dr. Ilgenfritz's book covers an important part of the field of general surgery. We are reminded in the Foreword that the greatest recent advances in surgery have been in the physiology of the care of patients before and after operations rather than in the operative technique. The successful combating of shock, hemorrhage, and infection has made possible much of the good results in newer applications of surgical treatment. This book deals individually with fluid and electrolyte balance, nutrition, transfusion, the importance of vitamins, and all of the new chemotherapeutic and antibiotic drugs.

Sedatives, before and after operation, are discussed, as well as the minor and major postoperative complications. There are chapters on intestinal obstruction and peritonitis, care of the wound, and shock. Each of the regions has a separate chapter, except the nervous system.

"Preoperative and Postoperative Care of Surgical Patients" is a large book and contains a wealth of material with many references to the literature at the end of each chapter. Controversial subjects, such as early rising after operation, are discussed, giving the opinions pro and con, with a tendency to favor the conservative.

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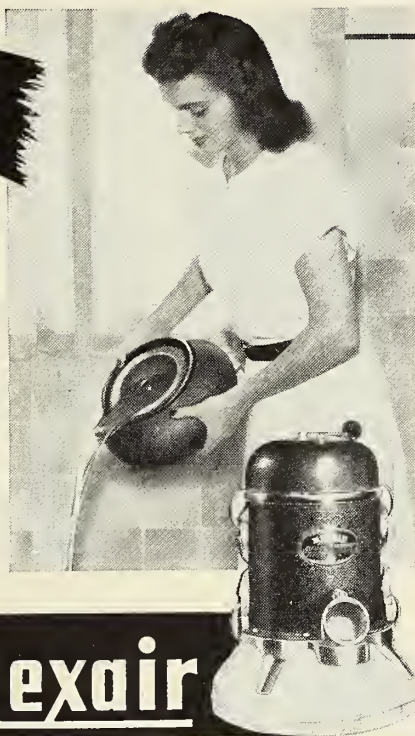
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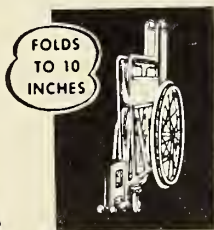
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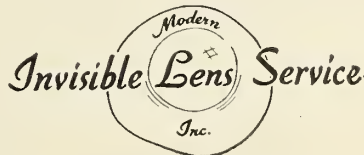
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MICROBIOLOGY AND PATHOLOGY. By Charles F. Carter, M.D., Instructor in Pathology and Applied Microbiology, Parkland Hospital School of Nursing, Dallas, Texas. Fourth edition. 845 pages, with 216 illustrations and 25 color plates. Cloth. Price \$5.00. The C. V. Mosby Company, St. Louis, 1948.

"Microbiology and Pathology" is primarily a textbook for nurses. The original edition was based on a book by the author on "Bacteriology for Nurses." The present book, the fourth edition, includes the fundamentals of microbiology. It points out the importance of microbes in disease, in agriculture, and in industry.

An important part of the present revision is the section dealing with the antibiotic drugs. Infectious hepatitis and homologous serum jaundice are discussed. New chapters added are "The Hospital Pathologist and His Work," and "Defects in Body Development." Much of the book is devoted to pathology. There are many illustrations of laboratory apparatus and of laboratory and immunological methods. There are many pictures of pathological conditions with several plates in color.

This book should be an excellent addition to any classroom or library for nurses or technicians.

Pierce MacKenzie, M.D.

EDUCATION FOR PROFESSIONAL RESPONSIBILITY.

Written by educators in schools of divinity, medicine, law, engineering and business, for the purpose of interchange of ideas and experience, this report presents a remarkable unity in the opinions expressed. Yet each of these five disciplines can learn from the others and all can derive much from the proper integration of humanistic and social studies. All agreed upon this last point, except for one physiologist who presented the purely mechanistic point of view. He was answered in a most interesting (and arresting) manner by a professor of philosophy.

To the medical man the second and third sessions of the conference are of greatest interest, especially the one on content and method in professional education. "Clinical training of the medical student is largely conducted nowadays by the case method. The introduction to principles of practice, and methodology may be taught in part didactically, but the real *piece de resistance* is the clinical clerkship, which actually amounts to an apprenticeship." Medicine seems to be ahead of the other professions on this particular point, although the divinity schools are beginning to provide "clinical experience" for their students.

At the third session it was stated that "whatever the many reasons may be, the entering medical student of today is less informed (or is misinformed) in the psychologic and social aspects of human behavior than he is in the physical and chemical aspects." Regarding personal attitude of the medical student, "traditional teaching methods must be prefaced and constantly accompanied by attempts to recognize and deal with the various emotional reactions which are mobilized by teaching experiences. The student must be helped to understand and manage his anxiety about the subject matter before he is able to assimilate the knowledge and use it effectively." Most doctors have had to perform this psychologic feat for themselves, since it is essential in developing "the bedside manner." This entire section on "Social and Humanistic Aspects" is well worth reading by prospective student, the teacher, and the practitioner alike.

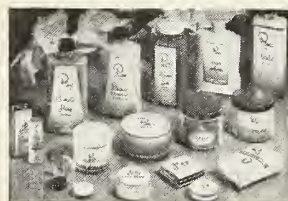
A. W. C.

HEALTH EDUCATION. A publication of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. Cloth. 413 pages. Price, \$3.00. Quantity discount. Order from the American Medical Association, 535 N. Dearborn Street, Chicago 10.

A completely rewritten 1948 edition of this standard textbook and guide for teacher education is now available. Under the editorship of Charles C. Wilson, M.D., Professor of Education and Public Health at Yale University, and a revision committee composed of Thurman B. Rice, M.D., Professor of Public Health, Indiana University, Bernice Moss, Ed.D., Department of Health and Physical Education, University of Utah, and W. W. Bauer, M.D., director of health education for the American Medical Association, the contributed material of nearly one hundred outstanding leaders in health education has been organized into a comprehensive, readable and up-to-date volume.

Present-day problems with solutions proved effective by experience are discussed in the twenty chapters under such titles as Health Problems: Past, Present and Future; Solving School and Community Health Problems; Finding and Using Resources and Health Education in Action.

Although the book is closely indexed for ready reference, the clear, non-technical presentation of material makes "Health Education" excellent as a textbook or for supplementary reading. Modern typography and a liberal number of photographs and tables highlight the text.



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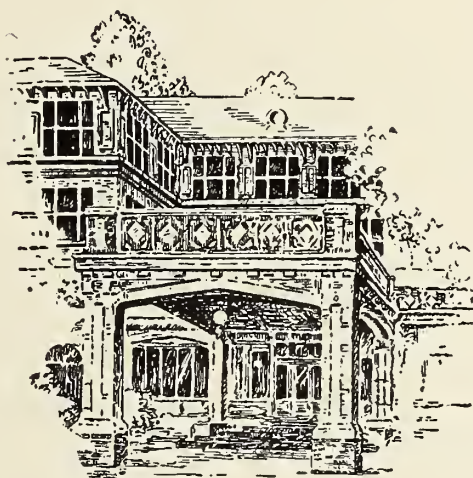
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THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

★ SEE PAGE 397 FOR CURRENT ADVERTISERS.

X-RAYS PLAY PROMINENT ROLE IN CHECK UP ON PNEUMONIA PATIENTS

A Pennsylvania radiologist urges that study and care of pneumonia patients should be continued until all pulmonary shadows disappear in the x-ray check ups of the lungs.

Writing in the current issue of *The American Journal of Roentgenology and Radium Therapy*, Dr. C. L. Hinkel, of Danville, Pa., says that "most chronic pulmonary diseases causing disability today can be traced back to a previous pneumonia of some sort from which the patient failed to recover fully."

"It is evident," he continued, "that accurate diagnosis and intelligently directed complete treatment of the pneumonia patients being cared for today will materially lower the incidence of chronic pulmonary disease in the future."

He explained that due to the "masking effect" of the antibiotic drugs, which are used so successfully today in treating pneumonia, the symptoms and clinical signs of pneumonia soon disappear, but "the pathological and physiological changes within the lungs do not always keep pace with the clinical improvement."

"There is a strong tendency," Dr. Hinkel said, "to get pneumonia patients 'up and out' earlier and to forget that there are sequelae which can and do lead to chronic pulmonary invalidism."

HEALTH FACTS FROM YOUR STATE BOARD OF HEALTH

Indiana's 1949 revision of the state hospital and health center plan for 1950 construction is the first 1949 plan of any state to receive the approval of Surgeon General Leonard A. Scheele, United States Public Health Service, according to Dr. Martha O'Malley, director, Division of Hospital Services, Indiana State Board of Health.

The 1949 plan, as developed by the Indiana State Board of Health and the Indiana Advisory Hospital and Health Center Planning Council, was the first revision of the Indiana plan submitted since the original outline was devised May 15, 1947. This plan was also one of the first to be approved by the United States Public Health Service.

States are required by the federal hospital survey and construction act to revise the state plan annually in order to be eligible to receive federal funds for hospital construction.

Approximately \$5,205,448 has been allotted to Indiana for hospital construction.

Construction of hospitals has already started in the following counties: Rush, Whitley, Tipton, Harrison, Lagrange, Fayette, Randolph (Union City), Fayette, Allen (Lutheran) and a public health center in Lake county at Gary.

Plans are proceeding for building either new hospitals or additions in the following counties: Washington, Hancock, Perry, Allen (Irene Byron), Lake (Mt. Mercy), Hamilton, Knox (Good Samaritan), Dubois, Clark, Lawrence (Dunn), Wayne (Reid), Pulaski, Marshall and Marion (Sunnyside).

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EMBRYOGENIC MEGACECUM COMPLICATED BY VOLVULUS

CASE REPORT

PAUL K. CULLEN, M.D.

INDIANAPOLIS

THE so-called normal cecum in the adult is a large, blind pouch, situated below the colic valve, at the beginning of the colon. The estimated¹ average size of the cecum is said to be 6.25 cm. in length and 7.5 cm. in breadth.

The entity I have chosen to call embryogenic megacecum is a gigantic cecum developed out of all proportions to the so-called normal cecum. It is situated below a well-attached ileocolic segment, and has no semblance of a vermiform appendix. An example of this type of cecum, measuring 16¼ inches in length, after deflation, is illustrated in Figure I of the accompanying case.

It seems probable that an embryogenic megacecum is the creation of an unusual embryologic developmental anomaly of the cecum and vermiform appendix; and that it is not what is generally referred to as a megacecum, or Hirschsprung's disease, in a restricted segment of the colon.

A cecal pouch of such proportions is of interest, not only because it may become the site of torsion, but because of speculation concerning its origin and formation. Although longitudinal volvulus is uncommon and usually occurs in the ileocecal segment of the colon, it may also occur in a cecum of abnormal redundancy.

Volvulus of the cecum² is responsible for not more than 5 or 6 percent of all cases of intestinal obstruction. A review³ of one hundred and thirty-six cases of acute intestinal obstruction from the records of The Mayo Clinic showed but one case in

which volvulus of the cecum and ascending colon occurred.

Chalfant⁴ stated that an abnormal mobility of the cecum and ascending colon is a prerequisite to the development of a volvulus in that part of the intestinal canal. This abnormal motility has been thoroughly studied by Harvey.⁵ Chalfant reported a case of torsion of the cecum, and studied one hundred and eighteen cases reported by Bundschuh,⁶ Kohler,⁷ Corner and Sargent,⁸ Satterlee,⁹ and Morley.¹⁰ Of these one hundred and nineteen cases, twenty-three patients who were not operated upon died. Of the remaining ninety-six who underwent some type of surgical procedure, fifty-seven died. The total mortality was 67 percent. Dixon and Miller¹¹ reported two cases of volvulus of the cecum which were diagnosed and operated upon early, with recovery. Ericksen and Greenfield¹² recently described a case of volvulus of the ascending colon.

A perusal of the cases presented in this review of the literature shows the site of volvulus to be above the ileocolic valve; and that the most frequent cause of torsion of the ileocecal segment of the colon is due to an abnormal mobility of the cecum and ascending colon usually designated as mobile cecum. I have been unable to find any record of volvulus of the cecum, wherein the torsion is located below the colic valve, in an ileocecal segment which is secured by a so-called normal mesentery; nor have I been able to find any record of a gigantic cecum without a vermiform process, such as the cecum presented in the following case report.

Figure 1



CASE REPORT

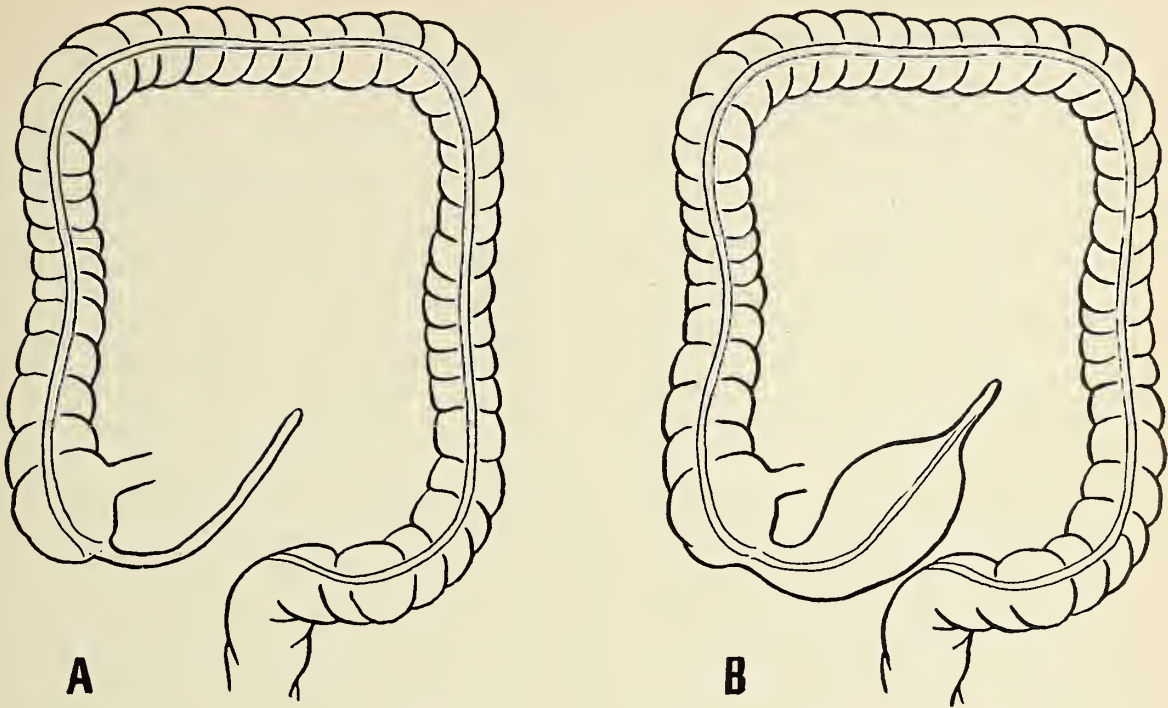
U.S.N.H., Great Lakes, Illinois, June 28, 1943. J. E. B., white male, 39 years of age, was admitted complaining of generalized abdominal pain, severe and cramping in character, and associated with almost constant vomiting. According to his history, the patient's general health has always been good. There is no history of a serious illness. The present illness started about twelve hours before admission, with sudden abdominal pain and vomiting. The patient states that since early childhood he has had frequent attacks of sudden, severe, abdominal pain. He discovered, as a boy, that he could get relief from these attacks of abdominal pain by lying on his back and stretching his abdomen. He has had no previous medical attention for this condition. Family history is irrelevant.

Examination elicits a fairly well nourished, and well developed man, who is acutely ill with excruciating abdominal pain; associated with vomiting. The head and neck are essentially normal, except for dental caries. Inspection of the chest shows respiratory excursions to be bilaterally equal but limited and rapid, because of abdominal distention. Upon percussion and auscultation, the lung fields are clear. The heart is in normal position and of normal size. No murmurs are heard. The rate is rapid and the rhythm normal. The blood pressure is 100/75. The abdomen is enormously distended, tense, and tympanitic. The abdomen seems to be completely filled with a tympanitic mass, which is not movable. The entire abdomen is exquisitely painful upon palpation. Upon auscultation of the abdomen, no bowel sound can be heard. Rectal examination reveals an intra-abdominal mass ob-

structing the anal canal, by pressure. Laboratory study of blood and urine give findings within normal limits. X-ray of the abdomen shows marked gaseous distention of an obstructed bowel. The physical findings and the x-ray findings being indicative of a massive, acute bowel obstruction, probably of the colon, it is felt that immediate surgical intervention is indicated. Naso-gastric suction is instituted to relieve vomiting.

Operative report: Under spinal anesthesia the abdomen was prepared by ether and tincture of merthiolate. The abdomen was opened through a right rectus incision of the Moynihan type. Upon entering the abdominal cavity, a moderate amount of free fluid was encountered. The presenting mass, which was recognized as colon, was so large and tense that the examining hand could not be passed into the abdomen for exploration. A purse-string suture was placed in the presenting colon and the distention relieved by means of a trocar, after which the purse-string suture was closed. After this procedure, the examining hand was passed into the abdominal cavity, and about the greatly distended bowel. The upper pole of the mass was then recognized as an enormous cecum measuring $16\frac{1}{4}$ inches in length, after deflation, from its tip to the point of obstruction. (See Figure I.)

The point of volvulus was noted to be just below the ileocecal juncture, at which point there were four complete longitudinal twists. There was beginning necrosis at the site of volvulus. Inspection of the ileocecal segment of the colon showed it to be attached by normal mesenteric attachments. Only this enormous cecum was free of any attach-



ment. Resection of the entire cecal mass was accomplished by ligating the cecum immediately above the point of volvulus with a silk ligature. The cecum was excised and the proximal stump treated with phenol and alcohol, and inverted by means of a silk purse-string suture. Further examination of the ileocecal segment of the colon failed to reveal an appendix. Inspection of the resected segment failed to show an appendix. The abdomen was closed in layers, without drainage. Postoperative convalescence was completely uneventful. Laboratory study of the resected segment of cecal volvulus showed it to be large intestine in its structure. Because of the swelling of the specimen and the extravasation of blood cells, particularly into the mucosa, the mucosal crypts are stretched far apart. There is no indication of lymphoid tissue, either diffuse or nodular, which would rule out appendix.

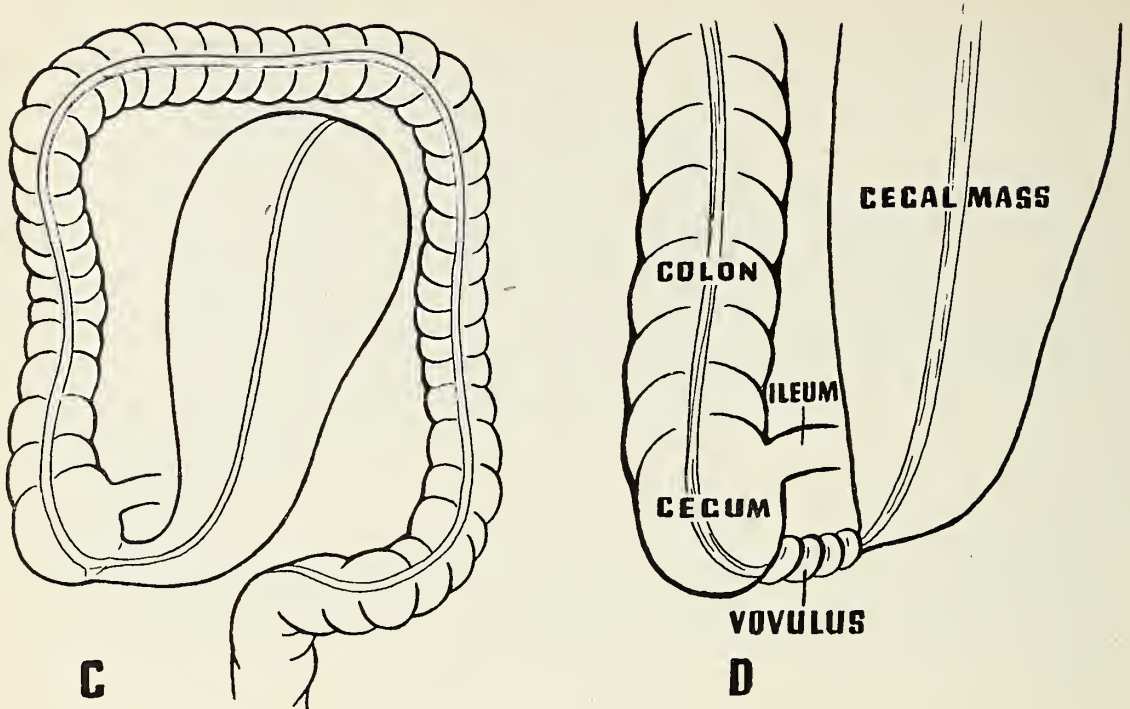
COMMENT

A large cecum is characteristic¹³ of most herbivorous animals with simple stomachs, and a vermiform appendix is not present in these animals. Mammals are popularly known as animals, the name of the class being derived from the fact that most mammals possess mammary glands which secrete milk for the nourishment of their young. Primates, the highest order of animals, are those with fingers usually terminating in nails, such as the lemurs, monkeys and apes. Although the vermiform appendix is found to be a functioning digestive organ in vertebrates such as reptiles, fish, and birds, it is not found in any animal species¹⁴ except the Primates; and in this group it is only found in the more highly developed

animals. A differentiation of the tip of the cecum appears first in the cynomorphous apes and this is the first trace of an appendix. In the anthropoid apes the arrangement is essentially the same as in man.

The cecum and vermiform appendix in man are developed in the following manner. In embryos¹⁵ of 4 weeks (5 m.m.) the intestine is a simple tube, beginning at the stomach and ending at the cloaca. From 5 to 9 m.m., a bulging in the caudal limb indicates the cecum and, consequently, marks the boundary between the small and large intestine. The ascending colon, beginning to elongate as such in the middle of fetal life, is not completed until early childhood. The original cecal bulge grows and makes a definite blind sac that extends the large intestine beyond its junction with the ileum. The distal end of this sac lengthens rapidly for a time, but eventually lags greatly in thickness. As a result, the characteristic vermiform appendix of higher apes and man becomes distinct from the cecum.

The human cecum varies in shape; but according to Treves,¹⁶ in man it may be classified under one of four types. In early fetal life it is short, conical, and broad at the base, with its apex turned upward and medialward toward the ileocecal junction. It then resembles the cecum of some monkeys, e.g., the Mangabey monkey. As the fetus grows, the cecum increases in length more than in breadth, so that it forms a longer tube than in the primitive form and without the broad base; but with the same inclination of the apex toward the ileocecal junction. This is seen in other monkeys, e.g., the Spider monkey. As development goes on, the lower



part of the tube ceases to grow and the upper part becomes greatly increased, so that at birth there is a narrow tube, the vermiform process, hanging from a conical projection, the cecum. This is the infantile form, and as it persists throughout life in about 2 percent of cases.

In the second type, the conical cecum has become quadrate by growing out a saccule on either side. These saccules are of equal size, and the appendix arises from between them. This is found in 3 percent of cases.

The third type is the normal type of man. The two saccules which in the second type were uniform have grown at unequal rates, the right with greater rapidity than the left. As a consequence of this, an apparently new apex has been formed by the growing downward of the right saccule, and the original apex with the appendix attached is pushed over to the left toward the ileocecal junction. This type occurs in about 90 percent of cases. The fourth type is merely an exaggerated condition of the third: the right saccule is still larger, and at the same time the left saccule has become atrophied, so that the original apex of the cecum, with the vermiform process, is close to the ileocecal junction. This type is present in about 4 percent of cases.

Comparative studies by Rickett¹⁷ show that in fetal and early infant life the appendix is funnel-shaped, and that there is no valve of Gerlach until several months after birth. The fetus of man may possess an appendix as long and as great in diameter as that of a giant. This study also shows that those animals which live upon highly nutritious

foods, that require but comparatively few changes to prepare it for absorption into the body, have small rudimentary ceca or none at all; while those that feed upon vegetable matter possess a large cecum. Ricketts believed that the continued presence of the cecum in the higher orders of vertebrates is evidence of nature's attempt to make use of an organ that has lost its original function. In further comparative study by DeNeen,¹⁸ an appendix was found to resemble a cecum in a fetus of about three and one half months. He cites another case in which two vermiform appendices were found in a man. The findings in these cases are indicative of an embryological reversion to the lower order of vertebrates.

Drennan¹⁹ states that environment determines function and function determines structure. Animals ascended from a certain common type, on account of different environments, develop different functions and, consequently, different structures. It is by evolution, not by revolution, that nature achieves her ends. There is every reason to believe that the granivora preceded the carnivora; the vegetable kingdom preceded the one that fed upon flesh. The carnivora retain a vermiform appendix to which no function can correctly be attributed. Since man has organs well suited for both varieties of digestion, he is not in need of a reservoir for his vegetable diet; and the vermiform appendix which he has is simply a rudimentary organ of a state out of which he has slowly evolved.

These studies of the cecum and appendix show that the vermiform appendix, in man, is not the atrophic vestige of the embryonic cecum; but that

it is the remains of an organ to which no present function can correctly be attributed, and that it is possible to have an embryological reversion to a primitive state. It seems probable that the entity I have chosen to call embryogenic megacecum is the creation of an unusual embryologic developmental anomaly of the infantile cecum and vermiform appendix, that during the middle of fetal life, when the cecal bulge grows and the distal end of this sac lengthens rapidly, there is no lagging at the end to form the characteristic vermiform process; but that the tip of the cecal bulge is utilized in the longitudinal growth of the tube to form a gigantic cecal pouch as shown in Figures A, B, C, and D.

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CHEMOTHERAPY IN PEDIATRICS*

SOME DO'S AND DON'T'S

MILO K. MILLER, M.D.

SOUTH BEND

LITERAL interpretation of the submitted title limits its theme to a discussion of true chemical substances. It does not include the broader consideration of antibiotics.

The sulfonamides are the first drugs in history which can be introduced into the body in sufficient concentration to inhibit the growth of bacteria without injuring the tissues of the host. They are effective in certain infections where penicillin fails, notably in bacillary dysentery, bacillus pyocyaneus, and Hemophilus influenzae. In addition, penicillin and streptomycin fastness is being encountered with increasing frequency.

The most widely accepted theory of the mode of action of the sulfas is that, due to some as yet unknown interference with the normal cellular metabolism of bacteria, their multiplication is slowed up, frequently resulting in destruction of

the organism. Certain sulfonamides, including sulfadiazine, sulfathiazole, and sulfamerazine, are absorbed readily from the gastro-intestinal tract, while certain others, such as sulfaguanidine, are poorly absorbed. Absorption is greatest from the small intestine, is accelerated by sodium bicarbonate, and delayed if the drug is given after a meal.¹

After the sulfonamides are absorbed from the intestine several things happen to them. Among these are:

1. Ionization.
2. Binding to plasma proteins.
3. Conjugation.

Sulfathiazole and sulfadiazine are ionized almost completely, sulfanilamide only slightly. "Since the degree of bacteriostasis achieved is proportional to the amount of ionization, it follows that the concentration of sulfanilamide or any other poorly ionizable drug would need to be higher than sulfathiazole or sulfadiazine to produce similar therapeutic results."²

* Presented at the General Meeting of the Indiana State Medical Association, at the annual session in Indianapolis, October 27, 1948.

Table 1

Relative Rate of Absorption and Excretion and Degree of Ionization, Binding and Conjugation of Various Sulfonamides (Compiled from Various Sources)

Drug	Relative Rate of Absorption from Intestines	Relative Rate of Excretion by Kidneys	Relative Degree of Ionization	Relative Degree of Binding with Plasma Proteins	Relative Degree of Conjugation
Sulfanilamide	1	1 or 2	4	5	4
Sulfapyridine	4	3	3	4	1
Sulfathiazole	2	2 or 1	2	2	3
Sulfadiazine	4	4	1	3	3
Sulfamerazine	3	5		1	2

A portion of any sulfonamide present in the blood stream is bound to plasma proteins. Binding to plasma proteins is of importance because the unbound portion is apparently inactive therapeutically.

Conjugation, or the addition of an acetyl group to a certain proportion of sulfonamides, probably takes place in the liver. The acetylated forms are inactive therapeutically.

The absorbable sulfonamides are distributed throughout the various organs and fluids of the body, their penetration being influenced by the amount of ionization and the degree of combination with blood proteins. The sulfonamides diffuse into the cerebrospinal fluid and into body fluids, including the pleural fluid, the saliva, pancreatic juice, and bile. The small amounts secreted in

mothers' milk are apparently harmless to the infant. The concentration of sulfathiazole in the spinal fluid reaches about 30 percent of that in the blood; sulfamerazine about 50 percent; and sulfadiazine about 75 percent.

The sulfonamides are drugs of first choice in meningococcal meningitis, in *Shigella* dysentery, and in certain urinary infections. They are used advantageously in combination with antibiotics in other kinds of bacterial meningitis and meningococcemia. In certain infections where penicillin or streptomycin may be the drug of choice, sulfonamides may be used instead. These include pneumococcal, gonococcal, and hemolytic streptococcal infections. They may be especially useful in types of infections which show antibiotic fastness.

The dosage for oral administration of the sulfonamides in children is based on body weight, usually 0.06 to 0.12 grams (1 to 2 grains) per pound of body weight per day, given in six evenly divided doses at four-hour intervals throughout the twenty-four hours. One-fourth to one-half of the twenty-four-hour dose is given as an initial dose. In certain severe infections, such as meningitis, as much as three grains have been used advantageously. Except in the use of sulfamerazine, the doses should not be decreased in amount, nor should the intervals at which they are given be increased as the patient improves. Full dosage should be employed for the entire course of treat-

Table 3

Choice of Therapeutic Agents in Treatment of Various Bacterial Infections

Table 2
Choice of Therapeutic Agents in Treatment of Various Bacterial Infections

	Penicillin	Streptomycin	Sulfonamides	Specific Serum
Infections Coli-Aerogenes Group				
Peritonitis	1C	1C	1C	
Bacteremia		1	A	
Meningitis		1	A	
Urinary Infections		2	1	
Hemophilus Influenzae		1	A	A
Tularemia		1		
Tuberculosis		1		
Tetanus				1
Diphtheria	A			1
Gas Gangrene	A			1

	Penicillin	Streptomycin	Sulfonamides	Specific Serum
Pneumococcal Infections				
Pneumonia	1		2	
Empyema	1			
Meningitis	1C		1C	
Streptococcal Infections				
Beta Hemolytic (except Scarlet Fever and Meningitis)	1		2	
Scarlet Fever	1			
Meningitis	1C		1C	A
Non-hemolytic (Alpha and Gamma)	1			
Staphylococcal Infections	1			
Meningococcal Infections				
Meningitis	A		1	
Meningococcemia	1C		1C	
Gonococcal Infections	1	2	2	
Typhoid		?		
Salmonella Infections		?	?	
Shigella Dysentery		?	1	A
Brucellosis		?	?	

- 1—First Choice
2—Second Choice
1C—First Choice, combined with other drug shown
A—Adjuvant in Certain Cases

- 1—First Choice
2—Second Choice
1C—First Choice, combined with other drug shown
A—Adjuvant in Certain Cases
?—Value Questionable

ment, instead of diminishing the dose with improvement in the patient's condition.

In mixed sulfonamide therapy the most desirable combination is that of sulfadiazine and sulfamerazine, thus eliminating the more toxic sulfathiazole. This may be given at six or eight-hour intervals around the clock.

For children, flavored candy tablets, or better still pleasant liquid mixtures, most of which are combined with alkali, are preferable to ordinary tablets. Tablets should always be crushed. The crushed tablet, if mixed with a little brown sugar, then enough water added to dissolve it, will be well accepted by most children.

Gilbert B. Forbes, George Donnel and John Herweg,³ after four years of critical comparison, prefer subcutaneous administration of 1 to 5 percent sodium sulfadiazine solution to infants and young children rather than intravenous use of a 5 percent solution. The cited advantages are:

1. Ease of administration.
2. Leaves veins available for other purposes, if needed. (Many patients requiring parenteral chemotherapy are dehydrated on admission to the hospital, and should receive fluid promoting blood volume and diuresis before intravenous chemotherapy.)
3. Can be maintained easily over long periods of time.
4. Adequate amounts of fluids can be given simultaneously with the drug. If indicated, urine can be alkalinized by incorporation of M/6 sodium lactate solution.

The rationale of prophylactic use of sulfonamides is based on these facts:

1. Rheumatic fever frequently occurs within a few weeks of streptococcic infection.
2. This is associated with a rise of antistreptolysin titer in the patient's blood.
3. The incidence of recurrence of rheumatic fever is less in patients three to twelve years of age taking sulfadiazine in one gram daily doses from September 15 to May 15. Coincidental improvement of environmental factors, such as a deficiency in protein, Vitamin B complex, Vitamin D, and minerals, is important.

The optimal blood levels, reached within one to six hours after giving, have been found to be:

- 10 to 15 mgm. per 100 cc. for sulfanilamide and sulfamerazine;
- 8 to 10 mgm. per 100 cc. for sulfadiazine;
- 4 to 6 mgm. per 100 cc. for sulfathiazole.

In practice, however, clinical results suffice. Occasionally an increase in dosage, or added intravenous administration, will produce an increased blood level and improvement in the patient.

Untoward reactions to the sulfonamides were studied by Fink and Smith.⁴ They are listed as:

1. Gastro-intestinal. Nausea and vomiting, (1st to 2nd day of administration), thought to be due to central nervous system stimulation, rather than to gastric irritation.
2. Renal. Hematuria, oliguria, anuria. (1st week of administration.)
 - a. Mechanical obstruction by crystals.
 - b. Toxic.
3. Neurologic. Mental disturbances. (1st to 2nd day of administration.)
4. Blood and blood-forming organs. Leukopenia, anemia, hemolytic anemia, jaundice, purpura. (1st to 2nd week of administration.)
5. Systemic. Fever, with or without rash, occurring alone or in combination with any of the above reactions.
 - a. Initial administration. (5th to 9th day.)
 - b. Subsequent administration. (1st 24 hours.)

Their conclusions from the detailed study of 5,000 cases were that reactions to sulfonamides are very infrequent in children, and rarely cause serious disease. Danger of severe reaction to subsequent sulfonamide administration usually exists only when febrile reaction occurred previously. "There is apparently no greater reason to fear harmful effects from multiple courses of drug therapy than from the first course." Reactions with sulfathiazole are much more common than with other drugs.

Experience has shown that, if patients receiving sulfa therapy are watched carefully, if the drug is stopped upon the first sign of toxic reaction and fluids are given freely, most toxic reactions will rapidly disappear.

The indiscriminate and repeated use of sulfa drugs for all types of minor infections, particularly the common cold, is to be avoided. It is an especially dangerous practice to use drugs left over from a previous illness without the careful supervision of the physician.

Table 4

Untoward Reactions to the Sulfonamides

1. Gastrointestinal—Nausea and vomiting (first to second day of administration).
2. Renal—Hematuria, oliguria, anuria (first week)
 - a. Mechanical obstruction by crystals.
 - b. Toxic.
3. Neurologic—Mental disturbances (first to second day).
4. Blood and blood-forming organs—Leukopenia, anemia, hemolytic anemia, jaundice, purpura (first to second week).
5. Systemic—Fever, with or without rash, occurring alone or in combination with any of the above reactions.
 - a. Initial administration: Fever with or without rash (fifth to ninth day).
 - b. Subsequent administration: Fever usually with rash (first twenty-four hours).

The administration of large amounts of alkalis to patients with cardiac or renal insufficiency is a dangerous practice.

Exposure of patients taking sulfa drugs to sunlight, ultra-violet or infra-red rays should always be forbidden, in order to avoid photosensitization.

Mechanical deposition of sulfonamide crystals within the renal tubules is the recognized cause of kidney lesions. Methods employed to prevent this crystallization have been:

1. The attempt to produce a dilute urine by forcing fluids.
2. Producing an alkaline urine with drugs to minimize crystallization.
3. The present increasing tendency to use a mixture of sulfonamides rather than single compounds.

According to Lehr, Slobody and Greenberg,⁵ two or more compounds, when present simultaneously in water or urine, do not have any influence upon their individual solubilities. Thus three sulfa compounds could be dissolved simultaneously to the point of full saturation of each compound when present alone. The concentration of the three drugs represents, therefore, the sum total of their individual solubilities. The therapeutic significance of this lies in the fact that sulfathiazole, sulfadiazine, and sulfamerazine are similar in their antibacterial activity, which, in a mixture of compounds, is found to equal the total concentration of the free sulfonamide present. Thus by employing a mixture of drugs it is possible to give a rather large total quantity of sulfonamides with relative safety; a single compound in the same dosage

would be much more toxic. The risk of crystalluria, however, is proportionate only to the amount of single drugs present.

TO SUMMARIZE THE DO'S AND DON'TS—

1. Give adequate doses in suitable types of cases, combined, if indicated, with antibiotics.
2. Be certain to give adequate amount of fluids.
3. Give adequate alkalis to help avoid crystalluria.
4. Give drug in form that children will take well.
5. Give mixture of drugs, preferably sulfadiazine and sulfamerazine.
6. Sulfathiazole is most likely to produce toxic reactions and crystalluria.
7. Discourage self-medication with "left-over" drugs.
8. Have patients avoid photosensitization.

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THE SOUTH BEND CLINIC,
122 N. Lafayette Blvd.,
South Bend, Indiana.

Voice of Medicine

March 14, 1949.

Editor,
Journal of the Indiana State Medical Assn.,
Indianapolis 4, Indiana
Dear Sir:

I would like to announce the establishment of the American Academy of Neurology, whose purpose it is to further and encourage the practice of clinical neurology and to stimulate teaching and research in neurology and allied sciences.

Active Membership in the Academy is open to every physician who has been certified in neurology or in both neurology and psychiatry. Junior Membership is available to physicians presently engaged in postgraduate studies in neurology or who are awaiting certification in neurology. In addition, there is an Associate Membership for those who are not certified in neurology but whose interests are in fields related to neurology. It is hoped that because of the unrestricted membership, this association will be representative of the entire neurological specialty and will offer an organ of expression for many of the younger men in the

field. The American Academy of Neurology at present has 500 members. The first business meeting was held in Chicago in June, 1948.

The first scientific meeting will be held at the French Lick Springs Hotel, French Lick Springs, Indiana, on Wednesday, Thursday, and Friday, June 1, 2, and 3, 1949. Dr. Dave B. Ruskin of the Caro State Hospital, Caro, Michigan, is in charge of the scientific program.

The present executive council consists of Dr. A. B. Baker, Minneapolis, President; Dr. Pearce Bailey, Washington, D. C., Vice-President; Dr. Joe R. Brown, Minneapolis, Secretary-Treasurer; Dr. Frederic Lewey, Philadelphia; Dr. William A. Smith, Atlanta; Dr. J. M. Nielsen, Los Angeles; and Dr. A. L. Sahs, Iowa City, Board of Trustees. Communications to the Academy should be addressed to Dr. Joe R. Brown, 19 Millard Hall, University of Minnesota, Minneapolis 14, Minnesota.

Sincerely yours,

A. B. BAKER, M.D.

President

American Academy of Neurology

INTESTINAL INFECTION AND INTRA-ABDOMINAL HERNIA INTO PREVESICAL SPACE

CASE REPORT

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TUCSON, ARIZONA

THIS case is being reported because of the extreme rarity of prevesical hernia. In a search of the literature this appears to be the eighth instance recorded. The virulent intestinal infection and other complicating features make this the first case coming to autopsy.

History: C. S., male, 57 years old, came to Tucson for relief of asthma and chronic sinusitis in September 1946. Beyond the usual findings consistent with this diagnosis he also had a left inguinal hernia and some prostatitis. On routine management he improved markedly. In May 1947 he decided to go back East to liquidate his affairs and move to Tucson permanently. He drove to New Jersey and returned here June 20, 1947. I received a phone call on June 22 telling me that he, his wife and daughter all had diarrhea, nausea, and other gastro-intestinal symptoms. They were given ordinary telephone advice and told to come to the office if they got worse.

The next day the wife and daughter were better, but C. S. was worse and came to the office. There was some low, right-sided pain, with nausea and general malaise. Temperature was normal, as was the urine. Sedimentation rate was 5; wbc. 9,300; rbc. 4,800, Hg. 90 percent, and normal differential. He was given some trisentine and phenobarbital, enemas, and heat to abdomen. On June 25 some epigastric pain appeared and he began to vomit very sour material. Intravenous Calcecorbate and 50 percent glucose was given after gastric lavage. On June 27 he grew worse and was sent to the hospital with a tentative diagnosis of a typhoidal gastro-intestinal state. Temperature was still normal but the white blood count was down to 2,500. He developed marked abdominal distention and Wangensteen suction was inserted. Extreme suprapubic tenderness appeared and urine could not be passed. On the use of a catheter, bloody urine was obtained. The urological consultant (Dr. Don Lewis) could not explain the blood but thought the source of trouble was extra-urinary. Flat plate of abdomen showed suggestive "staircase" bowel pattern. Gastric drainage began to be suggestively fecal. The temperature began rising slowly but the white blood count was down to 2,200; stool and urine cultures and blood serology for various bowel pathogens were negative. The surgical consultant (Dr. R. Rudolph) saw the patient on June 29 and agreed that there was some type of intestinal obstruction.

On operation several loops of distended bowel

were found. These were traced down and a knuckle of small intestine some two feet above the ileocecal valve was found caught into an opening in the anterior abdominal wall about an inch to the left of midline in the left lateral ligament of the urinary bladder. The bowel released readily and Dr. Rudolph was able to close the hernia hiatus. The incision was routinely closed with interrupted catgut sutures. The patient at this time had a temperature of 104°, pulse 100, wbc. 2,100. General condition appeared rather good.

For some four days postoperatively he did quite well. Continuous Wangensteen suction, blood transfusions and plasma were given. Temperature continued elevated and now the white blood count went up steeply to around the 20,000 mark. On July 7 there was an obvious general peritonitis and the patient expired in vasomotor collapse that evening.

The pertinent autopsy findings were:

1. Abscess of the rectus muscles with perforation into abdominal cavity and generalized peritonitis.
2. Early bronchopneumonia.

No pathology to explain the urinary symptoms of the preceding week was found.

Microscopic section through the necrotic rectus muscle showed only considerable necrosis with extensive degeneration of the muscle bundles. Cultures of the peritoneal fluid were sent to the Salmonella Typing Center in Lexington, Kentucky. They reported "atypical coliform bacillus which sometimes produces a pathological condition."

COMMENT

Intra-abdominal hernias into the prevesical space are extremely rare. C. W. Mayo,¹ in discussing 39 cases of intra-abdominal hernia, does not even mention this type. L. K. Stalker² reports a case of his own and reviews six other cases he was able to find in the literature. His diagrammatic sketch fits exactly into our case. Fifteen years ago Walker³ had an excellent discussion of this topic.

Why our patient had a massive hematuria was not explained. The fact that the intra-abdominal hernia was just above the bladder could explain irritative bladder phenomena but not the alarming bleeding.

Also unexplained is the causative agent of the original peritonitis. It is very difficult to accept the "atypical coliform bacillus" as the primary infectant. More than likely all three members of the

family ate contaminated food on their transcontinental trip and acquired the same infection simultaneously. The wife and daughter recovered readily while the father went on and became fatally ill. I believe the hernia occurred while he was retching. The extremely low white blood count and almost typical typhoidal onset would point to a typhoid or *Salmonella* organism but none were recovered at any time. The 1:40 agglutination of the Widal reaction is certainly inconclusive. Some type of intestinal virus has not been disproven. The muscle necrosis was more than likely simply a case of "locus minoris resistentiae." The closure was with interrupted sutures throughout and certainly there was no obstruction of the circulation or tension on the sutures. The patient received enormous amounts of penicillin, blood, and fluids to maintain his protein and mineral balance and bacterial resistance. The bowel caught in the hernial sac released readily at operation and there was complete restoration of bowel function before death. All in all, the patient

appeared to have died from an overwhelming toxemia of which the muscle necrosis was merely an expression rather than a cause.

SUMMARY

An extremely unusual case of an overwhelming intestinal infection of undetermined etiology, complicated by an intra-abdominal hernia into the prevesical space, has been presented. This is the eighth case of this type of hernia in the literature and the first with an autopsy report.

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TREATMENT OF CHRONIC BRUCELLOSIS WITH SODIUM BISMUTH TARTRATE

A REPORT OF SIXTEEN CASES

W. L. WISSMAN, M.D.

T. D. CARPENTER, M.D.

COLUMBUS

WE ARE indebted to the contagious ward of Indianapolis General Hospital and to Dr. Gerald Kempf, staff consultant of the contagious ward of that institution, for the impetus to use this type of therapy in undulant fever. Heavy metals in a variety of combinations have been used in the therapy for numerous diseases. The rationale for bismuth therapy probably lies in the effectiveness of the heavy metal. We feel that undulant fever is a disease commonly encountered in private practice and infrequently diagnosed. For this reason it is felt that the results with this type of therapy will be encouraging to the general practitioner.

In this cursory and early report of the cases, the outstanding clinical picture at the time of examination and institution of therapy was: (1) easy fatigability; (2) vague muscular aching, usually involving the low back and extremities; (3) vasomotor disturbances, mainly flushing, not unlike the so-called climacteric hot flashes; (4) apathy in facies and mood; (5) recurrent attacks of so-called flu. In all of these cases positive skin tests, using 1/10 cc. of Brucellin Antigen, and a high titer

agglutination from the blood, were found. We believe that any titer agglutination from the blood is significant if present with above symptoms, history, and a positive skin test. No blood cultures were obtained.

It is not within the scope of this brief report to deal with diagnosis. It is known that even with the above described subjective complaints and laboratory procedures one can not possibly diagnose Brucellosis in 100 percent of the cases. Much has been written about the neurogenic factor in the symptomatology of this disease, and in our experience the apprehension, chronic complaining, and general outlook of these patients have been materially benefited by this therapy.

The preparation employed was 1.2 percent bismuth sodium tartrate diluted in 8 cc. of distilled water. In most cases ten injections were employed and in two cases twenty such injections were used. The preparation was injected intravenously, in the antecubital fossa vein, daily, for five doses. The succeeding five injections were varyingly spaced, depending upon the therapeutic response of the individual patient. In twelve of the sixteen cases

thus treated, marked improvement in symptomatology was noted at the end of the fifth injection. The remaining four had varying amounts of remission. Two cases treated with the total of ten injections over a period of fourteen days showed no response to the therapy. The last five injections were given over a period of ten days. Two cases had a total of twenty injections, five daily and then spread through the succeeding three weeks. One of these had a remission of symptoms and the other had only moderate improvement.

Regardless of their present occupation or habitat, all of these cases had in the past or present lived in rural areas and had consumed raw milk and/or handled uncooked beef or pork. The dura-

tion of symptoms varied from six months to twenty years in these cases. It was interesting to note that only three of the sixteen had been previously diagnosed as Brucellosis. In these three the Brucellosis Antigen, neoarsphenamine and symptomatic treatment had been ineffective in previous treatments.

To summarize, sixteen cases were treated, twelve of which had complete remission of symptoms, two had some amelioration of symptoms, and two were not benefited. These cases, however, had only been clinically observed for a period of twelve months; therefore, future prognosis using this type of therapy must be guarded until further study of these cases and others can be effected.

MODERN TRENDS IN ANESTHESIA

RUTH WEYL, M.D.

CHICAGO

A YEAR ago the Morton Centennial was celebrated in Boston. On October 16, 1846, William Morton, the dentist, administered ether for a surgical procedure at the Massachusetts General Hospital.¹ It was the first time in history that ether was successfully used in the operating room. It was a great event, and it had the greatest consequences. Ether anesthesia was accepted almost instantly and today ether is still probably the most widely used anesthetic agent. And yet, anesthesiology has come a long way since then. Our whole outlook is different today.

Now, as then, we want the patient not to endure any pain and to emerge safely from the procedure. But the possibilities of securing this aim are vastly multiplied, and we are much more critical as to the safety of any anesthetic procedure.

Anesthesia today takes advantage of the progress that has been made in physiology, chemistry, pharmacology, and the related sciences, and anesthesiologists have contributed their part to the progress. Exact knowledge of the physiology of external breathing, of the carriage of oxygen and carbon dioxide, in the blood, of the exchange of gases in the tissues, of the pathology of the heart and brain, are only a few examples of what the competent anesthesiologist has to know of modern science, to be able to judge the condition of the patient adequately before and during the operation, and to make anesthesia safe.

The pictures of anoxia, hypoxia, and atelectasis are so imprinted in the mind of the anesthesiologist of today that he is on the constant lookout for even minor changes in the condition of the patient, during the operation and postoperatively.

The physiology of position, the knowledge that in some positions, for instance the Trendelenburg position, the vital capacity is halved² or even more

curtailed, and that in others, for instance the Fowler's position, the circulation time is increased,³ help us in dealing with poor risk patients.

It has been shown that in healthy patients premedicated with morphine, sitting up can induce fainting,⁴ a fact that must be known by one who does operations, like tonsillectomies or trigeminal operations, with the patient in the sitting position. The now well established fact that anoxic breathing is reflex breathing due to reflexes from the carotid and aortic body, is another example of how the development of physiology helps to make anesthesia safer. We know today that once the respiratory center is depressed by anoxia, narcotics and excessive carbon dioxide tension, breathing is carried out entirely by this reflex mechanism, which is the ultimum moriens of the respiratory regulating system.^{5 6 7 8 9} To the respiratory center anoxia is only depressant. The hyperpnea, the hypertension, and tachycardia associated with acute anoxemia, are due entirely to reflexes from the carotid and aortic bodies. Thus breathing is likely to cease when severe anoxemia is suddenly removed by getting oxygen into the lungs. Therefore we must be prepared to do artificial respiration in this event. Oxygen should be used early and every effort should be made to keep the patient well oxygenated at all times.

Carbon dioxide, the most powerful stimulant during normal conditions,¹⁰ is not a stimulant for the severely depressed center; on the contrary, it adds to the depression.¹¹ The anesthetized patient has to be protected from carbon dioxide accumulation, not from carbon dioxide lack. So must the newborn baby. And if we give coramine or metrazol or picrotoxin to the severely depressed patient, we not only increase the depression,¹² but we actually increase the oxygen want of the higher center,^{13 14}

by increasing the oxygen demand. Thus an already anoxic patient is made more anoxic by the increased tissue demand that follows the administration of a stimulant. Therefore the most recent trend is no carbon dioxide and no stimulants in asphyxia. This is the very opposite of previous training, when it used to be a reflex on the part of the doctor to give a stimulant in every kind of respiratory or circulatory emergency. And, of course, we do not give a stimulant if obstruction is the cause of asphyxia. The indications then are to relieve the obstruction, get the airway clear, and get oxygen into the lungs. In giving stimulants to the patient with a normal respiratory center, we increase the oxygen demand, and if the obstruction persists the only result is that there is more oxygen want than before. The same is true if we are dealing with an atelectasis. Rapid pulse, dyspnea, and cyanosis may induce an inexperienced person to inject a stimulant and increase the oxygen want, while the proper procedure is to inflate the atelectatic lung, to use suction to get the plug out of the bronchi, to thump the chest, to turn the patient, to make him cough; all this, but no chemical stimulant. Under these circumstances carbon dioxide should be used to stimulate deep breathing and help to expand the lungs, provided the respiratory center is not yet depressed by anoxia, or has already been restored to normal by our efforts.

The modern anesthetist is conscious at all times of the damage anoxia, even of short duration, inflicts to the brain, to the heart and to the adrenals. Anoxia of the brain results in unconsciousness in five seconds,^{15 16} and the cerebral cortex can resist anoxia only for five minutes.¹⁷ After this time death of the cortical neurons occurs, as well as widespread permanent brain damage. Permanent resuscitation through cardiac massage in cases of cardiac arrest is only possible within this time limit of five minutes.¹⁸

Knowing these facts, it is hard to understand why hypoxia was tolerated by anesthetists so frequently during the last century. Descriptions of patients under nitrous oxide always included duskiness and slight cyanosis. In using one procedure, the so-called "secondary saturation method,"¹⁹ the anesthetist achieved relaxation under nitrous oxide anesthesia by deliberately inflicting anoxia on the patient, and then at the very last moment, when the patient was turning blue and the pulse weak, filled the lungs with oxygen, and had the patient recover. If insufficient relaxation recurred later, the procedure could be repeated! If nitrous oxide is given, as it used to be, and as some dentists still do today, with less than 20 percent oxygen in the inhaled mixture, then the proportion of oxygen in the inspired gases is below 13.7 percent and the arterial oxygen tensions are in the range of extreme asphyxia: 30 mm. of mercury.²⁰ In a patient with a normal or high blood count, the apparent cyanosis will be a warning even to the most imprudent anesthetist, who is administering nitrous oxide, or

any other agent, for that matter, with less than 20 percent oxygen; but in the anemic patient or the patient with hemorrhage, where the red count is so low that there is less than 5 Gm. percent reduced Hb. per 100 cc. of blood, even this warning is absent. Therefore special caution has to be taken with anemic patients. Generalized convulsive seizures, muscular rigidity, and persistent coma may follow anoxia.^{21 22} The patient may survive to show decerebrate rigidity. Changes of personality may occur; bright students may become backward just after having had a short anesthetic, for instance for a tooth extraction. Thus anoxia and prolonged hypoxia may be followed by the most severe consequences.

The modern anesthetist aims to have his patient well oxygenated at all times. Each case should be individualized. Some patients, for instance patients with thyrotoxicosis, use up more oxygen in the unit of time than patients with a normal metabolism, therefore more oxygen should be supplied. The same is true for children and patients with fever. The condition of the patient, and not any rules or percentages, is the only guide. At no time should any patient be allowed to breathe an anesthetic mixture containing less oxygen than the atmospheric air.

If, however, for any reason anoxia occurs, through hemorrhage, through fall in blood pressure, or due to apnea caused reflexly or by depression of the respiratory center, through laryngospasm, or for whatever reason, there is complete agreement today as to what is to be done in such an emergency. Pure oxygen should be supplied at once. If the patient does not breathe, artificial respiration should be instituted, if the airway is clear, by using bag and mask. Sufficient pressure must be applied to the bag to be able to inflate the lungs adequately. If the airway is obstructed, it must be made patent, if need be by inserting an endotracheal tube, nasally or orally. Often it is enough to pull the patient's chin forward, or to insert a pharyngeal airway to relieve the obstruction. If no bag or mask is at hand, something that should never happen when anesthetics are being administered, an attempt can be made to blow into the patient's mouth²³ until bag and mask can be supplied. The tidal volume of air required to maintain normal oxygen saturation of the tissues and to eliminate carbon dioxide satisfactorily is 400 to 500 cc. Far too many surgeons and anesthetists, in case of an emergency, try to do manual artificial respiration, by pressing on the ribs, using the Schaefer method or the Silvester method, according to the position of the patient, and are amazed if they do not get results. Comroe and Dripps²⁴ measured the tidal air produced by the Schaefer technique, and found that it varied from 71 cc. to 117 cc., (compared to the necessary amount of 400 cc.). The Schaefer method depends to a large extent on the elastic recoil of the lungs, and that has disappeared in the apneic patient, who is asphyctic

and in shock. To do effective resuscitation, oxygen has to be brought into the lungs in sufficient amount and carbon dioxide has to be eliminated, too, otherwise there is increasing narcosis due to the accumulation of the carbon dioxide. The best way to do this, if available, is by pressure on a bag filled with oxygen. Prevention of an overdose of the anesthetic agent as a prophylactic measure, and the ability of the anesthetist to recognize and handle respiratory obstruction are two great essentials in anesthesia.

If the apnea and oxygen want is caused by convulsions, for instance following novocain injection, we must stop the convulsions first, by administering a sedative, preferably a barbiturate, such as pentothal sodium in 2½ percent solution intravenously, injecting slowly, until the convulsions stop. Here again we must avoid stimulants.

Recently we had occasion to see three so-called novocain reactions within two days. Novocain can cause allergic reactions, such as wheezing or sneezing in allergic persons, or convulsions followed by respiratory difficulties or cardiac arrest in sensitive patients, or if inadvertently given intravenously or in too great amounts. In our first case, an elderly woman, lying on her abdomen, had been injected with 1 percent novocain without adrenalin in conservative amounts about ten minutes previously for a hemorrhoidectomy. When we saw her she was completely apneic, deeply cyanotic, unconscious, and pulseless. We turned her over on her back at once, inserted an oral endotracheal tube, and inflated her lungs through the endotracheal tube by pressure on the bag. Within a minute her color became pink, we could feel the pulse at the wrist, and after another minute she started to breathe on her own, but at very long intervals. In checking the premedication we found that she had been very heavily premedicated; since she was a heavy woman, her respiratory exchange had not been good in the prone position, probably from the very start, and after the morphine took full effect and her jaw relaxed, she probably developed oxygen want from central respiratory depression and obstruction of the airway. In this case I am sure we did not deal with a novocain reaction at all.

The second case was a healthy young man who was to undergo a tonsillectomy. The surgeon had injected local novocain (without adrenalin) into one tonsil, and had just started injecting the second tonsil when the patient turned pale, felt faint, and started to perspire. He was sitting up and had had morphine premedication. The surgeon's question was whether he should cancel the operation or proceed. When the patient was lowered into the supine position his color returned and his pulse became stronger. We concluded that we were dealing with one of those patients who does not tolerate the sitting position after morphine. The surgeon was advised to proceed without injecting more novocain, with the patient in the semi-supine position, and the pro-

cedure was completed uneventfully. In this case, however, the patient was warned to report this incident to his dentist, or whenever he was to have another local anesthetic.

On the same day, one hour later, we had a real novocain reaction. An elderly, very sick patient with a decompensated heart, emboli, and edema of the legs, was given novocain 2 percent (without adrenalin) by her surgeon, in the form of a paravertebral block to alleviate pain in the legs. The injection was not completed when she suddenly started to have the most violent convulsions. The procedure had been done in the patient's room. When we saw her she was very cyanotic, having convulsions, and no pulse could be felt. Emergency treatment consisted of mouth-to-mouth breathing, while oxygen, an endotracheal tray, and pentothal sodium were being brought to the room. Everyone cooperated, and within two minutes we had the oxygen machine, and could supply oxygen by bag and mask. It did not bring about much change in the deeply blue color of the patient. In the meantime the endotracheal tube had arrived and the patient was successfully intubated through the nose, and the lungs were inflated. We were able to control the convulsions by slowly injecting 2½ percent solution of pentothal intravenously. We stopped injecting as soon as the convulsions stopped, but kept the needle in the vein for future use. We had to breathe for her for a few minutes by means of the oxygen bag, but then she started breathing spontaneously, and made an uneventful recovery.

In none of these cases did we use any stimulants.

We want to say a few words about the use of the endotracheal tube, one of the most important single achievements in modern anesthesia. In 1542, Vesalius passed a tube through a cut in the throat of an animal, the thorax being open, and the lungs exposed. By blowing air into the tube, he was able to maintain artificial respiration.²⁵ Trendelenburg, a surgeon, was the first to use this procedure in man in 1869, to prevent aspiration of blood during an operation on the upper air passages.²⁶ Macewen succeeded in inserting an endotracheal tube through the mouth by the sense of touch, in 1880, instead of performing a tracheotomy,²⁷ and Kuehn achieved nasal intubation with good results in 1902.²⁸ He had a keen vision of the tremendous importance of endotracheal intubation. During the first World War great improvement in endotracheal technique was achieved by Magill in England,^{29 30} and today the technique of endotracheal intubation with a wide bore tube is in general use. By this method the tube is inserted under direct vision through the mouth, with the help of a laryngoscope, or blindly through the nose, enabling the anesthetist of today to maintain a free airway at all times, and in all positions, to do away with the interference of laryngeal reflexes, to facilitate successful surgery of the lungs, and to get the anesthetic equipment

completely out of the surgeon's field, in operations of the brain or face.

The endotracheal tube is invaluable in resuscitation. As soon as the tube is inserted the anesthesiologist is master of the situation, provided the heart is still beating. He is certain of getting air into the lungs, the danger of inflating the stomach is avoided, and aspiration is prevented, especially if a tube with an inflatable cuff is used.^{31 32}

In dealing with atelectasis, also, the endotracheal tube is of the greatest importance. Through the tube we can apply suction to the bronchi and get out the mucus plug that causes the atelectasis, and then inflate the atelectatic lung. In many instances it is lifesaving, as in the case of a fourteen year old boy, who was being operated on for an injury of the hand. The operation was a drawn-out affair, but everything went well for about one hour. At that time the pulse accelerated. The nurse-anesthetist was inclined to attribute this to the fact that the patient had lost quite a bit of blood, and wanted to start intravenous fluid administration. We did not think that the blood loss in this kind of operation could cause such an increase in the pulse rate and looked for other reasons. The patient looked slightly cyanotic. By watching the boy's breathing for a few breaths and then placing the hands on his chest it became apparent that he had a complete atelectasis of the left lung. We tried to inflate the lung with bag and mask, without the slightest result. We then applied pressure to the left chest, without result. As the anesthesia was in the first plane, we intubated blindly through the nose, and aspirated the bronchi through the endotracheal catheter. There was an extremely large amount of fluid, ever increasing, so we injected atropine gr. 1/150 intravenously, and kept on aspirating, while applying oxygen through the tube, and lightening the anesthetic. Finally anesthesia was light enough so that the patient coughed when the suction catheter touched the carina. After that we could inflate the lung partially, and after another five minutes we were able to inflate the whole lung. When the boy left the operating room, both chests moved equally. He made an uneventful recovery.

Postoperatively it might be necessary to intubate a patient who has abundant secretions, and is too weak or too afraid to cough vigorously, even if there are no signs of atelectasis.

The development of endotracheal anesthesia by physician anesthetists is only paralleled in importance by the development of anesthesiology as a medical specialty.

Another great recent achievement is the development of the carbon dioxide absorption technique, first visualized in the present form by Jackson,³³ and brought into clinical use and perfected by Waters.^{34 35} But this method, which we use daily, concerns the anesthetist primarily and is of less

interest to the general practitioner or the surgeon in its details.

We have so many anesthetic agents at our disposal today and so many methods and techniques that we can select the anesthetic in each individual case and use the particular method that is best for each particular patient. In a young child we may choose the open-drop method and administer ether to avoid resistance and rebreathing and the child will do well. In a diabetic patient, ready to undergo a bowel resection, we will avoid ether because it induces hyperglycemia, empties the liver of glycogen, and may cause acidosis. We do not use nitrous oxide alone and struggle with oxygen want and poor relaxation, but we can use cyclopropane, a very potent agent that does not interfere with glycogen metabolism. Or if the same diabetic patient is suffering from asthma, so that cyclopropane is contraindicated because it is a vagomimetic drug and prone to cause an asthmatic attack, we can select a spinal anesthetic for him. We can use hyper- and hypobaric solutions for spinal anesthesia, according to the proposed operation, and thus make use of the laws of gravity to get the spinal anesthesia as high as the fourth thoracic vertebra, or to limit it, in the so-called "saddle-block," to the perineal area; or we can anesthetize just one leg for an amputation.

The prudent anesthetist aims to use as little of the anesthetic drug as is compatible with obtaining the best working conditions for the surgeon. That holds true for spinal anesthesia as well as for general anesthesia. Therefore, in "single dose spinal anesthesia," the close cooperation of the surgeon in stating his intentions is needed. Appendectomy through a McBurney incision, for instance, only requires anesthesia to D10, while for an appendectomy following gallbladder or stomach exploration, the anesthesia has to extend to D4, to be satisfactory without additional inhalation anesthesia. The approximate duration of the operation, too, influences us in the choice of the drug and the amount selected. Injection of small amounts of ephedrine, neosynephrin or other vasopressor drugs hypodermically before administration of the spinal anesthetic, helps to stabilize the blood pressure during the procedure, as does the administration of oxygen and intravenous fluids during operation.

As we have said before, there are innumerable possibilities of individualizing. Local blocks may be selected. Intercostal block for upper abdominal surgery in a very sick patient may give excellent results when done with care. Caudal anesthesia or transsacral block may be our choice for transurethral resection or hemorrhoidectomy. Brachial plexus block in suturing lacerated tendons assures the cooperation of the patient in locating the right tendon.

Each patient must be considered as an individual; his general condition, the kind of operation he is about to undergo, the expected blood loss, the posi-

tion on the table, the length of the anesthesia; all these things have to be taken into consideration to make a good choice. For a splenectomy, for instance, we will select ether anesthesia, since ether contracts the spleen, thus decreasing the blood loss, while cyclopropane or spinal anesthesia relaxes the spleen, increasing the amount of blood stored there and thus lost with the removal of the organ.

Inhalation anesthesia in first plane for a skin graft may be tolerated for several hours without any untoward consequences by the same patient who might go into shock if anesthesia in the third plane has to be maintained for one-half hour during a difficult bowel resection. Under these circumstances a spinal anesthetic might be preferable. If the operation is prolonged or if the patient is a particularly bad risk, and we chose a spinal, our choice probably will be continuous spinal anesthesia, using the method first described by Lemmon,³⁶ where a malleable needle or a suitable catheter³⁷ is left in the spinal canal. By this method we are able to start with very small doses of the anesthetic agent, and we can add small amounts of the drug according to the relaxation needed and the duration of the operation. The advantage of this method in bad risk patients is obvious. The method of continuous spinal anesthesia seems to me to characterize one of the most outstanding trends in modern anesthesia, the aim to make the anesthesia pliable, to give small doses at a time, to be able to withdraw if necessary, to inject more if necessary, and to be able to eliminate the anesthetic at any given moment.

We are not quite able to do that completely with our present agents, but we are on our way. It seems to us that the methods of prolongation of the duration of spinal anesthesia, either by the addition of drugs like adrenalin or the use of longer acting anesthetic agents than those at our disposal today, will not be our aim in the future, but rather the use of a nontoxic, short acting anesthetic agent that can be quickly withdrawn and eliminated and repeatedly supplied. There is the same trend in general anesthesia toward the use of shorter acting agents, and there is the same trend in intravenous anesthesia. Here the "single dose" method has been abandoned. The solutions used are becoming more and more dilute, the amounts actually injected become smaller and smaller every year, and here we come to another outstanding achievement in modern anesthesia, the so-called "balanced anesthesia." The term "balanced anesthesia" was suggested by Lundy³⁸ in 1926 to indicate the use of a combination of anesthetic agents and methods, so balanced that part of the burden of relief of pain is borne by the preliminary medication, part by local anesthesia and part by one or more of the general anesthetic agents.

Lundy³⁹ recently has suggested that as more anesthetic agents become available the tendency may be to use several agents and methods during a single operation. The advantage of this type of

balanced anesthesia is the greater flexibility, and the practically unlimited possibility to individualize, to select the agents to fit the patient. Moreover, the toxicity of the anesthetic procedure is lessened. In combining several agents one can use as little as possible of each and the least, of course, of the most toxic. Thus even the most toxic one can be used to advantage. Cyclopropane, for instance, in certain concentrations is known to cause cardiac irritation, arrhythmia, and it may cause laryngospasm. On the other hand, it secures quiet induction, quiet breathing, excellent oxygenation and is short acting. By combining it with adequate premedication and adding a small amount of ether, a sympathicomimetic agent, the disadvantages of cyclopropane are neutralized. This is an ideal combination, since the disadvantages of pure ether anesthesia, such as slow induction and slow emergence, increased secretion, hyperglycemia and disturbances of acid-base balance, are also avoided.

We may cite another example. Pentothal sodium, when first introduced, had some very definite contraindications; for instance, it was never to be used in operations on the throat or neck. It is a parasympathetic drug, and increases reflex irritability.⁴⁰ Laryngospasm, with ensuing oxygen want, and exaggerated carotid sinus reflex action may follow, and may induce apnea in a patient whose respirations are already severely depressed, since pentothal is a central depressant. It did not seem suitable in operations where relaxation is necessary, because a huge amount of the anesthetic drug, short of the toxic dose, is needed if it is used alone to cause relaxation. Today we can use it as follows. We anesthetize the throat of the patient very carefully, by local application, to abolish the reflexes that can cause laryngospasm; then start the intravenous injection of pentothal to get a pleasant induction; inject 20-40-60 units of curare intravenously to get the necessary relaxation; introduce an endotracheal tube under direct vision, to make aspiration impossible (for instance during a gastric resection) and insure adequate airway and quiet breathing. Then we can give any of the anesthetic gases through the endotracheal tube, (if cautery is needed, the anesthetic gas to be used must be nitrous oxide), supplemented with small doses of pentothal. All the contraindications have been taken care of, and if given right, the anesthetic wears off nearly as soon as it is stopped. Nitrous oxide alone can only carry a patient to the upper first plane; no relaxation can be achieved, but in combination with good premedication and a local block or curare or pentothal sodium, excellent relaxation can be obtained.

Curare, the ancient arrow poison, has proved to be a very satisfactory addition to our anesthetic armament. Brought to England by Sir Walter Raleigh, it was first investigated by Pelouse and Bernard in 1850.⁴¹ They demonstrated that curare causes respiratory paralysis, followed by asphyxia, thus causing death. H. R. Griffith⁴² and Stuart C. Cullen^{43 44} were the first to use it to obtain relaxa-

tion in anesthesia, after it had been used previously to mitigate the violence of convulsions in convulsive shock.⁴⁵ In intocostarin, an extract of the drug is available that is free from undesirable side effects and is standardized by biological assay. Sixty units (3 cc. of intocostarin) is an average dose for an adult, but 100 units (5 cc.) or more may be needed.* Curare is especially useful for relaxation in first plane anesthesia, and to stop laryngospasm or to make closure of the peritoneum possible, when a spinal anesthetic is wearing off. It is not an anesthetic and the conscious patient under curare suffers intensely if any operative intervention is performed; he is only unable to express his pain, since he cannot talk. The sequence of muscle involvement in curare paralysis is, first, the muscles that have cranial nerve innervation, then the muscles of the extremities, and lastly, the diaphragm. It acts on the neuromuscular junction, and the recognized antidote is prostigmine. Lately it has been proved that curare has a histidine effect,⁴⁶ and can itself cause laryngospasm and lower respiratory tract obstruction. Atropine premedication is desirable. A few special precautions should be taken before injecting curare. One should be sure that one is able to inflate the lungs, and we think curare should not be given if endotracheal intubation is not available to aerate the lungs in case of depression or complete apnea. Endotracheal intubation with a cuffed tube should be used to seal off the trachea, whenever vomiting or regurgitation is expected, as in a gastric resection, since the protecting reflexes are completely abolished even in light anesthesia. If used together with ether it must be given in very small doses, about one-third of the usual dose, because ether itself has a curariform action. Given intravenously it takes effect in about two minutes and the effect lasts about fifteen to twenty minutes. It can be repeated whenever needed. The relaxation is excellent. Sometimes the surgeon has to be patient and wait for full relaxation to occur.

In the diabetic patient if inhalation anesthesia is desired and relaxation necessary, the combination of cyclopropane and curare is ideal. With this combination there is no ether acidosis, no hyperglycemia, and speedy recovery from the anesthetic occurs so that the patient can move around and take nourishment early. The same is true for the very obese patient. Since a great amount of ether is needed to saturate the fatty tissues, emergence from the anesthetic with this slow acting agent is prolonged in fat people, while recovery is much speedier with the shorter acting cyclopropane and curare.

* Today the most widely used curare preparation is d-tubo-curarine chloride, the crystalline alkaloid salt prepared as aqueous solution. It is biologically assayed by the "Head Drop" method in rabbits and accurately standardized in units. (1 cc. contains a curare activity of 20 units, which is equivalent to 3 mg. of d-tubo-curarine chloride.)

There is one more point to mention as a very important part of balanced anesthesia, and that is adequate and well timed premedication. Claude Bernard, the great physiologist, stressed the value of premedication in 1869⁴⁷ and advised the hypodermic use of morphine during inhalation anesthesia to prevent shock and delirium. Today premedication is an integral part of the anesthetic procedure and has to be chosen with the same care as the procedure itself for each patient individually, according to the age and the metabolic rate of the patient and the anesthetic technique selected.

Every patient about to undergo an operation is apprehensive and under nervous tension. This is a perfectly normal reaction and the patient has a right to be relieved of this state of mind. A patient should come to the operating room calm, relaxed, and free of fear, but not too depressed. Reflex irritability should be decreased and secretory activity suppressed.

This state of affairs can be reached by premedication with narcotics, sedatives and belladonna-like drugs given in the right dosage, in the right proportion and at the right time. Premedication minimizes the amount of the anesthetic agent that must be inhaled. Experiments have proved that premedication with morphine lowers by 12 percent the amount of cyclopropane necessary to get relaxation without appreciably lowering the amount of gas necessary for respiratory arrest,⁴⁸ thus increasing the margin of safety. The same is true of pentothal sodium.

Adequate premedication increases the amount of oxygen that can be given with the weaker gases, nitrous oxide and ethylene, by insuring a low metabolic starting point.

Premedication with the barbiturates protects the patient against the toxicity of local anesthetic drugs. For many years it has been known that cocaine addicts use barbitol to counteract the excitement stage of their intoxication. Testing this experimentally in dogs, Tatum and his colleagues⁴⁹ found that administration of barbituric acid derivatives prior to the use of cocaine increases the lethal dose of this latter substance four times.

We know that secretion in an unpremedicated or not sufficiently premedicated child may be so abundant as to interfere seriously with the gas exchange through the alveolar membrane, so that induction may be very difficult.

Thanks to the brilliant work of Guedel,⁵⁰ there is complete understanding today of the different stages and planes of anesthesia and their respective signs. This knowledge is our great help in achieving the best working conditions for the surgeon, combined with the greatest safety for the patient under inhalation anesthesia. Always to know exactly in which stage or plane the patient is, and to know which plane is necessary for any

particular operation, is one of the secrets of good anesthesia. We do not allow the surgeon to touch a patient who is still in the excitement stage, and thus decrease the danger of ventricular fibrillation, which is greatest in this stage when the secretion of the adrenal gland is at its peak, and sensitizes the heart to several of the anesthetic drugs. Decreasing preoperative excitement by correct premedication is another help in preventing fibrillation.

Before the premedication is ordered by the anesthetist, or by the surgeon in consultation with the anesthetist, it should be decided which anesthetic procedure is to be used. Premedication that would be perfect for an operation under spinal anesthesia may make induction of general anesthesia difficult and hazardous. In a too heavily premedicated patient respiration may cease after a few breaths of a depressant anesthetic agent, or respiration may become so shallow and the minute volume so decreased that sufficient ether or gas cannot be inhaled to produce adequate anesthesia. Since, moreover, the slow and shallow respirations of the patient with respiratory depression decrease the exposed area of alveolar membrane so that diffusion through the membrane is lessened, anesthesia may be very hard to induce. Premedication with morphine for anesthesia, with the less potent drugs nitrous oxide and ethylene, both of which have a stimulating action on the respiratory center, may be as heavy as is compatible with adequate respiratory exchange; while cyclopropane, which has no such stimulating action, requires very light premedication. Therefore, the general condition of the patient must be studied carefully and the anesthetic procedure chosen before ordering premedication.

According to Guedel,⁵⁰ variations in resistance to anesthesia is largely a difference in the metabolic rate of the patient. The metabolic rate represents the grade of reflex irritability and oxygen demand. The higher the metabolism the greater the dose of the narcotic required. Metabolic rate not only varies with age, being very high in childhood and reaching its peak at puberty, but is influenced directly by pain, fever and emotional excitement. A child six years of age with acute appendicitis and a high fever, in an excited mental state, needs a large dose of premedication.

Endocrine imbalance influences the metabolic rate greatly. It is obvious to everyone that a hyperthyroid patient needs large doses of sedation, but it is too often forgotten that in a hypothyroid patient the routine dose may cause dangerous depression. In old age the metabolism is very low, therefore very little premedication is needed; the danger of depression is ever present here.

Careful studies have proved that the maximum effect of morphine given hypodermically occurs after 90 minutes.^{51, 52} This should be the time interval before operation for the hypodermic to be given. The time element is a most important factor.

Better no premedication than a hypodermic injection given fifteen minutes before the operation is started.

If a change in schedule arises and the operation is performed earlier than planned, the adequate dose should be given intravenously, slowly, while watching the patient for tinnitus, flushing and dizziness. Too little premedication can always be remedied by intravenous addition, if the initial dose has been given at the right time and has taken effect when we see the patient; but we are rather helpless if an adequate dose has been given and less than 60 to 90 minutes have elapsed, so that the full effect of the drug has not yet been obtained.

Morphine given intravenously can be accurately gauged and stopped when the desired effect is reached. The maximum degree of depression is reached within three to seven minutes after injection.⁵³ Start of anesthesia should therefore be delayed ten minutes after injection, so that one may be sure that the maximal depression has been reached before adding additional anesthetic depression.

Familiarity with one drug is a great advantage and morphine is the best hypnotic we can choose. It is reliable, readily available, and deterioration is infrequent. In proper dosage it is unsurpassed, especially if the patient is in pain. Demerol, one of the newer drugs, has proved to be a very helpful agent, combining morphine and atropine-like action, without causing the respiratory depression which morphine causes. The drug is rapidly broken down, probably in the liver, and its action therefore is of very short duration. It may be effective for only two hours. For all these reasons it is very valuable in obstetrical analgesia.

The undesirable effects of morphine, respiratory depression, nausea, and prostration are less frequently seen when morphine is combined with members of the belladonna group. Atropine was first introduced as a preanesthetic agent,⁵⁴ to prevent reflex stopping of the heart during induction of chloroform anesthesia by paralyzing the peripheral ends of the vagi. Nowadays, we do not give chloroform, but atropine remains one of our most valuable premedicants.

The usual dose of atropine or scopolamine, used as preanesthetic medication, has essentially no inhibitory effect on the parasympathetic system, except for that portion regulating the secretions from the salivary glands and the mucous glands in the mucosa of the oral and respiratory tract.⁵⁵ One to two mgm. doses are needed to get the paralyzing effect on the peripheral endings of the vagi to predominate.

In ether anesthesia, atropine is not necessary to paralyze the vagus nerve since ether depresses the vago-vagal reflexes, but it is of primary importance to reduce secretions. No ether anesthetic should be given without belladonna drug premedication.

In anesthesia with nitrous oxide and ethylene, gases that do not irritate the upper respiratory tract, there seemed to be little value in the use of atropine or scopolamine. But Reid and Brace⁵⁶ found that in any kind of anesthesia, be it nitrous oxide, ethylene, cyclopropane or ether, mechanical irritation of the upper respiratory tract, for instance by the introduction of a tracheal catheter, can cause reflex changes in the heart through the vagi; therefore, since morphine increases vagal tone, atropine and scopolamine should always be given with it.

No cyclopropane or pentothal sodium anesthesia should ever be started before premedication with either scopolamine or atropine has been effective, because both are parasympatheticotonic, and the combined action of morphine and cyclopropane seems to favor bradycardia and extrasystoles. Atropine is necessary to prevent these actions, to dry up secretions and to prevent and counteract laryngeal and bronchial spasm. The discovery of the importance of the vagal type of carotid sinus reflex enhances the importance of premedication with belladonna drugs. Sudden inexplicable deaths during thyroidectomies or other operations on the neck may have been due to stimulation of a hyperactive carotid sinus,⁵⁷ especially under pentothal or cyclopropane anesthesia.

Digitalis medication enhances the activity of the carotid sinus reflex,⁵⁷ therefore in digitalized patients one must be even more careful. Dosages of atropine up to gr. 1/75, preferably given intravenously, lessen the danger of this stimulation. This prophylactic premedication may be of the greatest benefit in such cases as drainage of infections of the neck, one kind of operation where the surgeon usually asks for "a whiff of gas."

Cardiac inhibition at the moment of constriction of a bronchus during lobectomy may be minimized by administering large doses of atropine;⁵⁸ and so may the severe laryngeal spasm and sudden drop in blood pressure that sometimes follow periosteal stimulation, as well as the bronchial spasm often occurring during anesthesia. In these cases the intravenous route is preferred and doses of gr. 1/75 may be used safely. As a rule the doses of atropine that are used preoperatively are frequently too small. In a healthy child of six years, doses of 1/200 are desirable, in preparation for ether anesthesia, and certainly a dose at least this large should be given to older children. The danger of atropine and scopolamine administration is overrated by some pediatricians. If marked excitement should occur, very small doses of apomorphine (gr. 1/60-1/40) will usually immediately quiet the patient.⁵⁹

Atropine should never be omitted in an obstetrical patient who is asleep under cyclopropane anesthesia. The injection of pituitrin, a very potent parasympathetic drug, which these patients often receive after delivery of the baby, adds considerably to the vagal stimulation caused by cyclopropane and nearly always causes bronchospasm

and laryngospasm, if not counteracted by previous atropine medication.^{60 61}

The increased peristalsis and intestinal contractions under spinal anesthesia are reduced to nearly normal by belladonna drugs. They are especially beneficial in cases of intestinal obstruction where the increased contractions resulting from the sympathetic inhibition may even cause the gut to rupture.⁶²

As to the question of whether atropine or scopolamine should be used preoperatively, the following data may be helpful. Both are potent respiratory stimulants and are valuable in offsetting the respiratory depression caused by premedication with morphine. Scopolamine is even more so.^{63 64} Scopolamine, in addition, reduces metabolism by reducing emotional excitement, and this is a great advantage. Waters and Guedel value the psychic depression caused by scopolamine very highly compared with the metabolic stimulation produced by atropine, and according to Waters, premedication with morphine and scopolamine in a ratio of 1:25 is the ideal premedication, given 90 minutes before operation.^{51 52} Waters considers scopolamine as the perfect psychic sedative, and attributes talkativeness and restlessness whenever encountered after scopolamine to deterioration of the drug. He is willing to discard a whole shipment⁵² when these effects are noted, and oxygen want as the cause of restlessness and delirium can be excluded. In the presence of uncontrolled pain, delirium may be expected under scopolamine, and in the very old it may cause restlessness, even if there is no drug deterioration. Atropine may then be used to greater advantage, as it is in infants.

Barbiturates in very large doses reduce metabolism directly, but in the doses usually employed for premedication this direct reduction is negligible. They are effective only in lowering increased metabolism due to emotional excitement, by allaying the emotional excitement. They usually produce delirium in the presence of uncontrolled pain. They are most profitably used to procure a good night's sleep before the operation, and as stated before, prophylactically before the use of a local anesthetic to prevent toxic reactions from the drug.

They are in no wise analgesic. Therefore, they are not substitutes for morphine and should be employed with great caution in patients with pain. If they are used in combination with scopolamine as preanesthetic medication without morphine, a small dose of morphine should be given before the end of the operation to prevent excitement from the pain stimuli postoperatively.⁶⁵ Even a shorter acting barbiturate such as nembutal will still be effective after the operation and may cause restlessness or depression. In large doses the barbiturates cause definite depression of the respiratory center, which may tend to increase the induction time of inhalation anesthesia, especially when they are combined with morphine.

Since some 1,500 derivatives of barbituric acid are on the market the selection of one barbiturate

over the other is often difficult. The intermediate group (nembutal, seconal) is the one which we use most often for premedication. They are destroyed in the liver, while the longer acting barbiturates are excreted by the kidneys. Therefore adequate hepatic and renal function must be assured when these drugs are to be used.

In our experience with very young children and infants, pentothal sodium and seconal premedication are well tolerated and make the course of anesthesia and convalescence much smoother.

The modern anesthetist holds himself responsible for the postoperative period. Search for incipient or marked atelectasis, aspiration of the bronchial tree, carbon dioxide administration, are some of his tasks in this period.

Greatest care should be taken to administer just enough morphine postoperatively to control pain, but not enough to produce respiratory depression and sleep, and worst of all to depress the cough reflex. The patient should move about in bed, move his legs, turn or be turned from side to side, and take deep breathing exercises, in order to avoid postoperative atelectasis and pneumonia. He should be made to cough up his secretions. It should be explained to him that there is no danger in coughing, and that the sutures will not break during the first few days after operation because he coughs. To do all this the patient must be awake.

There is no sadder sight for an anesthetist who protected a patient for three to four hours during an operation from respiratory depression and

atelectasis and sent him to his room awake and breathing well, than to come to the patient's room one hour later and find him lying on his back and snoring in deep sleep. The private duty nurse thought the patient was restless, there was a p.r.n. order, and so the $\frac{1}{4}$ gr. of morphine was given.

Postoperative sedation after pentothal sodium anesthesia should never be given before the patient had been awake and fully conscious for quite some time. These patients often can be aroused, but when they are left to themselves and are without pain stimuli, they go to sleep and may be very depressed.

It should not be forgotten that restlessness sometimes is caused by inadequate breathing and anoxia, and is relieved much better by clearing of the airway and oxygen inhalation than by administering morphine, which may make matters worse.

Anesthesia has come of age. Today the anesthesiologist, being an expert in judging and handling respiratory conditions, is called in as a consultant for all kinds of respiratory difficulties. He is called upon to administer therapeutic blocks. He is the judge of pre- and postoperative sedation, and of fluid administration during anesthesia. He is able and willing to procure adequate and safe anesthesia, and to take the entire responsibility for it, thus relieving the surgeon and allowing the latter to give his full and undivided attention to his important and specific task.

Due to shortage of space, the bibliography has been omitted, but will appear in the author's reprints.

UTILIZATION OF DDT

THE Federal Security Agency and the Department of Agriculture issued the following statement after a meeting of the principal Government agencies concerned with the utilization of DDT in national and international health and economy:

"A number of statements have been published during the last several days which have misled and alarmed the public concerning the hazards of using DDT as an insecticide.

"DDT is a very valuable insecticide which has contributed materially to the general welfare of the world. It has been used with marked success in both the control and prevention of such insect-borne diseases as malaria and typhus and of insects which are destructive to crops and injurious to livestock and infect homes.

"It is well recognized that DDT, like other insecticides, is a poison. This fact has been given full consideration in making recommendations for its use. There is no evidence that the use of DDT in accordance with the recommendations of the various Federal agencies has ever caused human sickness due to the DDT itself. This is despite the fact that thousands of tons have been used annually for the past four or five years in the home and for crop and animal protection. However, minor toxic symptoms may be produced by kerosene and various solvents used in DDT and practically all other insecticidal mixtures.

"Statements that DDT is responsible for causing the so-called 'virus X disease' of man and 'X disease' of cattle are totally without foundation. Both of these diseases were recognized before the utilization of DDT as an insecticide.

"The Food and Drug Administration has not prohibited the use of DDT in spraying dairy cattle and barns. The Federal Food, Drug and Cosmetic Act requires the Food and Drug Administration to insure that the food supply of the American people does not contain any poisonous or deleterious substance that is not necessary in the production of the food. Studies by the Bureau of Entomology and Plant Quarantine have shown that DDT, when used on dairy cattle or when present on fodder fed to dairy cattle, may appear in the milk. They also say that DDT in small quantities can be detected sometimes in milk, following ordinary use of the insecticide for fly control in dairy barns. Because of the vital importance of milk in the diet of infants, children and people of all ages, it is essential that proper precautions be taken to protect the milk supply. Modification of the recommendations made by the Department of Agriculture on the use of DDT on dairy cattle were made merely as a precautionary measure.

"There is no justification for public alarm as to the safety of the milk supply from the standpoint of DDT contamination."

ECHINOCOCCUS CYST OF THE LIVER

TWO PROVEN CASE REPORTS AND ONE SUSPECTED CASE REPORT

IRVIN H. SCOTT, M.D.

GARLAND D. SCOTT, M.D.

SULLIVAN

ALTHOUGH there is nothing new about echinococcus cyst in Australia, Iceland and some South American countries, it is rarely reported in North America, more particularly in midwestern states. According to Worthen and Thacier, in their article in *The New England Journal of Medicine*, August 1944, there have been only 482 cases reported in North America since the year of 1808.

The intermediate host of the tapeworm is ordinarily thought to be the sheep but it is a well known fact that the dog, the hog, the cow, and other unsuspected animals in this region may also serve the purpose. We are informed by one laboratory director that echinococcus disease is a very common cause of death to rabbits used for laboratory purposes.

The eggs are found in the intestinal tract of the respective host and passed in the feces. By some means the egg is ingested by the human in whose intestinal tract the larva is formed. The larva gains entrance into the portal circulation from the intestinal tract. It is then carried to the liver, in which the cystic state of the echinococcus disease is begun. The larva is first encased in a chitinous membrane around which a dense membrane is formed by a reaction of the surrounding tissue. The inside membrane is produced by the budding daughter cyst. From the liver the disease can gain entrance into the lung, peritoneum, kidney, brain, or any other structure of the body.

Since it is a known fact that there are so many species of animals in the midwest which can and do harbor the taenia echinococcus, possibly this parasitic disease is more common in this region than it is thought to be. Is it possible that many of the palpable nodular livers that the clinician encounters and passes off as cirrhosis or carcinoma of the liver could be multiple echinococcus cysts of the liver? The authors are of the opinion that any patient with a nodular disease of the liver which does not have other findings to prove a diagnosis should be examined with extreme care before echinococcus disease is ruled out.

Grossly, during operation, echinococcus cyst of the liver is to be differentiated from: 1. any polycystic neoplastic disease such as the cystic variety of teratoma; 2. the cystic type of abdominal tuberculosis, which is rare; and 3. syphilis of the liver.

Case I: Mrs. A. E. J., a white female, age 55 years, was admitted with her chief complaints being epigastric distress associated with occasional attacks of vomiting. These symptoms had been present to some degree at intervals for almost twenty years. She had also had many attacks of upper abdominal pain radiating to the angle of the right scapula, which had required hypodermics of morphine for relief.

Six years prior to admission she had noticed a "growth" at the right costal margin which had gradually increased in size. During the past one year the growth had increased in size very rapidly.

She had had five pregnancies, all terminating in normal deliveries and had passed an uneventful climacterium.

The family history was interesting in that she stated she had several relatives who had claimed they had "liver trouble." She states she had a cousin who had been operated several years before and had been told she had multiple "watery cysts" of the liver and spleen but a diagnosis had not been made.

Physical examination was essentially negative except for the abdominal findings. There was a large, tender, nodular mass which was easily outlined and extended to the right iliac crest. This mass was about the size of an adult's head and at the lower end contained a smaller nodule about the size of an orange which seemed slightly fluctuant. The other regions of the abdomen were normal.

Radiographic examination of the gastro-intestinal tract was negative except for the fact that the small intestine seemed to be pushed to the left of the mid line.

Erythrocyte count was 4,600,000 with a hemoglobin of 85 percent. The leukocyte count was 8,600. The urine revealed a trace of albumin and a few granular casts.

Operative findings revealed a large tumor, larger than an adult's head, arising from the right lobe of the liver. This tumor mass was not adherent to any of the surrounding viscera. The entire liver was studded with cysts which had a thick, leathery, smooth wall and were translucent. The cysts were easily enucleated and ranged from pinhead to orange size. The largest cyst, which involved more than one-fourth of the right lobe of the liver, was removed. Hemostasis was brought about by mattress sutures of chromic catgut.

The pathologist's report described a multilocular cyst lined by a chitinous membrane, external to which was an area of vascular granulation. The chitinous membrane contained bud-like processes which were recognized as scolices. The clear fluid in the cyst contained hooklets. A diagnosis of taenia echinococcus larval cyst was made.

This patient was subsequently treated with potassium iodide and made an uneventful recovery.

Case II: Mrs. H. Mc., age 45 years, stated that she had always been in good health until three weeks prior to admission, when she developed what she described as "attacks of gas pains." These attacks

of pain were in the epigastrium and radiated to the gallbladder region and to the angle of the right scapula. Following the attacks of pain she described chills and fever. She had been nauseated and had a loss of appetite since the onset of the pain. Her family physician had examined her and told her she had a large tumor in her liver. Her past history and family history were not significant.

Physical examination was negative except for the abdomen. There was a very large, round, symmetrical mass which was hard and extended from the xiphoid process to the umbilicus and moved with respiration.

Radiographic examination of the gastro-intestinal tract revealed no organic lesions but did show the stomach and small intestine to be pushed far to the left side of the abdominal cavity.

Laboratory findings were all normal.

When the abdomen was opened a very large, cyst-like tumor was found arising from the mid-portion of the right lobe of the liver. It was firmly adherent to the anterior abdominal wall. When the cyst was opened it was found to contain an inside lining in which was a milky appearing fluid. The inside membrane was easily enucleated and the cavity was carbolyzed. This cyst cavity was drained with a rubber tube gauze drain. The entire liver contained many pinhead to lemon size cysts. One area of the liver was excised for biopsy.

The pathologist's report described the membrane removed and the liver biopsy as echinococcus cysts of the liver. Daughter cysts and scolices were also described.

Following operative recovery this patient was given a series of x-ray therapy. She made an uneventful recovery.

Both Case I and Case II are alive after five years. Neither have a liver which is palpable.

Case III is a white male, 65 years of age, whom we have examined numerous times. He has large, cyst-like nodules in the liver region which vary in size from year to year. This patient is a close neighbor of the patient of Case II. He has made a livelihood by raising and training hunting dogs. He has never subjected himself to any surgical procedure or to skin tests. However, it is assumed that he also likely had echinococcus of the liver.

CONCLUSIONS

1. Echinococcus disease does exist in this region.
2. Echinococcus disease of the liver must be considered in any patient with a nodular liver, particularly if it is of long standing.
3. Surgical enucleation supplemented by irradiation therapy is said to be the treatment of choice.

THE ROLE OF HYPOTHERMIA IN THE TREATMENT OF VASCULAR LESIONS IN GERIATRIC PATIENTS*

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THE response of the body to cold depends, within limits, on the duration of exposure, the temperature, the types of refrigeration media, the character of the skin, the efficiency of the cardiovascular mechanism, and the conductivity of nervous tissue.

Cold applied locally or generally to the skin produces a vasoconstriction involving all surface vessels. As a result, the heat loss is diminished and the blood flow is reduced. This constriction phenomenon consists of three distinct responses.¹ The first response is local vasoconstriction due to the direct influence of cold; the second response, a transient, generalized narrowing of the vessel lumen, is due to impulses initiated locally at the receptor mechanism and disseminated by the autonomic nervous system; the third response is produced by the action of cooled blood on the heat regulating mechanism of the central nervous system and consists of generalized vasoconstriction. The skin is most important in thermic regulation, since heat may be dissipated or conserved. The underlying capillary bed and the arteriovenous

fulstulae are of paramount importance. Both respond directly to cold and indirectly through the nerve connections.²

Shortly after the immersion of an extremity in a cold medium, pain is initiated. After five to twenty minutes there is a diminution accompanied by a sense of warmth, due to transitory vasodilatation. During this period there is an intermittent increase in temperature from 5° to 8° C. (9° to 14° F.).³ With reduction in temperature the response becomes hyperactive until fatigue or paralysis inactivates this protective mechanism. The tissue temperature is then reduced to a level slightly above the environmental temperature.

The changes produced in sciatic nerves of experimental animals subjected to reduced temperatures vary from a conduction block to a complete necrosis of the axis cylinders.⁴ Damage to nerves may be observed with exposure to temperatures of 8° C. for a period of thirty minutes. The selective susceptibility of functional components indicated that the motor fibers were first affected, followed by fibers conducting sense of contact, touch and pain.⁵ It is interesting to note that reduced temperature can interfere with nerve conduction, pro-

* From a study made in the Miami Valley Hospital, Dayton, Ohio.

ducing a functional block without interruption of the distal fibers. Mild degenerative changes in the branches of the tibial and the peroneal nerves of man following refrigeration anesthesia have been recorded by Livingstone⁶ and Richards.⁷

Local application of ice produces sufficient skin anesthesia to permit incision of abscesses, removal of nails, and grafting of skin. The interruption of painful stimuli must be complete if such a procedure is to be useful in amputation surgery. For this reason the tourniquet has been recommended by Allen^{8,9} and Crossman.¹⁰

In our earlier series the technique recommended by Crossman, et al.,¹¹ was employed. Ice bags were placed at the tourniquet site, and the extremity was elevated for thirty to sixty minutes. A narrow, pure gum rubber tubing was then wrapped around the extremity two or three times and secured by a hemostat. The extremity was then packed in shaved ice and surrounded by rubber sheets with a trough at the end. The head of the bed was elevated to facilitate drainage. A refrigeration box described by Gordon¹² and Haley¹³ or a mechanical unit is more convenient.

The extremity remains in this medium for three hours if a thigh amputation is contemplated, or two and one-half hours for a leg amputation. The patient is then transferred to the operating room. Cool instruments, chilled saline, and chilled antiseptic solution should be employed.

In one of our cases gangrene developed distal to the tourniquet site. Ischemic gangrene probably resulted from, (1) an insufficient arterial blood supply due to sclerosis associated with a failure of the genicular collateral circulation or, (2) the constrictions of the arteries by the tourniquet prior to and during surgery. In the elderly group, collateral circulation develops very slowly. The utilization of refrigeration media to assist in the development of collateral circulation has been discouraging.⁶ The development of new techniques in arteriography may be of value in determining the optimum level of amputation.

"Stump complications" have been recorded by Grossman,¹⁰ Mock,¹⁴ and Hinchey.¹⁵ Although the tourniquet has not been identified as the factor responsible for these lesions, Blalock¹⁶ suggests that the tourniquet should be avoided if possible; and Pratt,¹⁷ Cayford and Pretty,¹⁸ and Taylor¹⁹ suggest the disadvantages encountered in the use of the tourniquet.

For these reasons the "two tourniquet technique" was adopted. The procedure previously described was modified by applying the tourniquet at the proposed amputation site. After a period of exposure to ice the patient was moved to the operating room. A second tourniquet was applied approximately ten centimeters below the original one, and the operative field was prepared after the first tourniquet had been removed. A guillotine type of amputation was employed. During this procedure, the neurovascular structures were anesthetized by

the injection of 1 percent procaine hydrochloride. Satisfactory anesthesia resulted from this procedure.

The obvious disadvantages of this technique are: (1) that a guillotine amputation is required; (2) that the period of anesthesia is limited; (3) that the metabolic products produced within the ischemic tissue between the tourniquets prior to amputation are absorbed.

Because of the undesirable effects of the tourniquet, additional techniques were sought. In patients acutely ill or severely debilitated, the risk of employing the tourniquet is unquestionably less than the administration of a general anesthetic. Cayford and Pretty¹⁸ report twenty-two limb amputations, eighteen of which were done without the tourniquet. The authors point out that five hours of refrigeration are required for a mid-thigh and four hours for amputations through the leg.

We next employed a supplemental anesthetic agent. A sufficient dosage of sodium pentothal intravenously was employed to produce narcosis without interruption of the corneal, proprioceptive, and pharyngeal reflex. Atropine sulfate, gr. 1/150, was administered hypodermically 45 minutes prior to the induction of anesthesia.

The hypothermia produces sufficient anesthesia to enable one to divide the skin, subcutaneous tissue, and muscles during the induction of the sodium pentothal anesthesia. This supplemental anesthetic agent abolishes the pain usually produced by the manipulation of the neurovascular structures and the retraction of the periosteum. As soon as this procedure has been completed and the vessels tied, the administration of sodium pentothal is discontinued, since skin anesthesia remains long enough to permit closure. Oxygen is administered during this procedure. By the time that the dressing is completed, the patient, although confused, is usually able to assist in being moved to the cart. Postoperative narcosis is brief, and postoperative nausea rare, since only one-half to one gram of sodium pentothal is used.

This survey includes an analysis of fifty-two unselected cases, all sixty-five years of age or over, admitted to the private and public services of the Miami Valley Hospital for treatment of vascular lesions of the extremity. We have excluded the younger group because we feel that hypothermia is extremely beneficial in the management of vascular lesions of geriatric patients requiring surgery. The age grouping, sex, and race are listed in tables I, II, and III.

TABLE I

Age	Control	Refrigeration
65-70	13	2
70-75	13	7
75-80	9	3
80-over	5	0
Total	40	12

TABLE II

Sex	Control	Refrigeration
Male	22	12
Female	18	0

TABLE III

Race	Control	Refrigeration
White	39	8
Colored	1	4

The cardiovascular, renal, and mental complications of the aging population are appreciated by all physicians. The dietary idiosyncracies of the elderly population produce avitaminosis and a state of malnutrition. The following table illustrates the debilitated condition of the patients in this study.

TABLE IV

	Control			Refrigeration		
	Good	Fair	Poor	Good	Fair	Poor
Condition on admission	5	26	29	0	6	6
Operative Risk (determined when surgery was contemplated)	14	12	14	0	2	10

The surgical management of this elderly group during the past decade has been unsatisfactory, as evidenced by the high mortality rate.

TABLE V

Mortality	Total	Death	Percentage
Case			
Refrigeration	12	2	16.7
Control	40	20	50.0

Since the medical, nursing and surgical care of these two groups is comparable, it is obvious that the reduction of the mortality rate as seen in table V is due entirely to the utilization of hypothermia. Therefore, any therapeutic procedure that is effective in reducing the mortality rate in this elderly group should be employed.

Veterans' Administration Hospital, McKinney, Texas.

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

A.M.A. EDUCATIONAL CAMPAIGN

DURING the planning and formative stages of the A.M.A. Educational Campaign, many indications have been given that it is well planned and will be well executed.

A few doctors have expressed disappointment that an immediate flood of publicity did not issue forth from Chicago, and that wide-scale advertisements did not appear in newspapers and on the radio. However, the fact that the campaign seems to be progressing slowly is evidence that every detail of the program has been meticulously studied and that every organization which will participate in it has been assigned an appropriate part in the coordinated whole.

It would have been easy to produce a sudden flash of hastily manufactured propaganda. This would have had a sensational impact, but would not have had any lasting effect.

The A.M.A. has very wisely adopted a soundly conceived plan which will move comparatively slowly, but because of this will be the more powerful. Its effect will be nonsensational, and therefore long lasting.

The literature and other items of campaign material which the A.M.A. is producing seems slow in making its appearance. One reason for this is that all the campaign writing is being checked and reworked to produce the most compact and highest quality material possible. A second reason is that all of it is being produced in lots of tremendous size. Most of the printing orders add up to many millions of copies.

Early in the campaign the fundamental plan was announced by the A.M.A. to the component state associations. This has allowed the state and county societies to develop their own programs in

such a way as to dovetail into and complement the national campaign.

The A.M.A. campaign has been set up and planned with two major characteristics.

First, it has been stressed from the beginning that it is an affirmative campaign. Doctors know that compulsory health insurance will produce poor medicine. The public should be told this and should be told why. However, the best way to prevent the adoption of compulsory insurance is to offer something better. Sound voluntary health insurance is the answer.

The 12-point program of the A.M.A. is another part of the affirmative approach which has been used in the campaign.

Most of the A.M.A. 12-point proposals, and voluntary insurance, are part of a gradually developed A.M.A. plan for the improvement of medical care. The fact that federal health insurance has become a political issue has highlighted the A.M.A. program, and the educational campaign will highlight it even more.

The assignment of high priority to the affirmative aspects of the plan is especially fortunate. Achievement of these objectives will not only defeat the drive for compulsory insurance this year, but also will make less likely the instigation and chances of success of future moves toward socialized medicine.

Secondly, the A.M.A. campaign has been designed as a broad, public campaign.

One advantage of the widespread publicity which has resulted from A.M.A. announcements has been that a large number of lay people who are interested in the free practice of medicine have been aroused and have become aware of the seriousness of the situation.

The A.M.A. campaign will continue to inform the people concerning the dangers of state medicine. At the same time they will be informed concerning the advantages of the plan which the medical profession is sponsoring.

Public opinion polls which have been reported in the daily press indicate that a large proportion of the people, when asked to state their views on socialized medicine and government health insurance, answer by saying that they do not know enough about the question to have an opinion. The need for stating facts through a widespread educational campaign is very evident.

If the people are acquainted with the type of medical care which is offered by government medicine; if they are cognizant of its cost, and realize its effect on medical progress; and if they understand the rationale of the A.M.A. program for the improvement of medical service, there can be no doubt as to the outcome.

INDIANA STATE EDUCATIONAL CAMPAIGN

THE officers and councilors of the Indiana State Medical Association, and the members of the Executive Committee, are to be congratulated for their prompt and energetic organization of Indiana's share of the A.M.A. Educational Campaign.

When the A.M.A. started the planning phases of the campaign, it was evident that certain of the activities of the drive could best be accomplished by the A.M.A. at a national level. It was also evident that other activities would naturally fit into the opportunities and facilities of the state and county societies.

The appointment of the Indiana A.M.A. Campaign Coordinating Committee, with Dr. Cleon A. Nafe as chairman, was made at an early date. This committee, with Dr. Carl H. McCaskey, Dr. Walter L. Portteus and Dr. Wemple Dodds as members, has been able to develop the campaign within the state in such a way as to amplify and reinforce the national activities.

The committee expects to distribute all the nationally prepared pamphlets and circulars direct to individual physicians. During the time required to print the A.M.A. pamphlets, a series of state pamphlets has been produced and mailed. Most of these are of a size which will permit inclusion in a statement-size envelope, thus simplifying the task of distribution.

A Speakers' Bureau has been functioning under the direction of the committee for several months. Many of the county societies have also set up such bureaus. Integration of the function of the several bureaus has resulted in the booking of speakers for lay and professional organizations.

The Coordinating Committee also plans to conduct an Endorsement Drive among various state organizations. This will supplement a similar drive which is being conducted among national organizations by the A.M.A.

Due to the fact that national radio programs could not be molded to conform to local conditions, this part of the publicity campaign has been reserved by the A.M.A. for the state and county societies. The Coordinating Committee has been proceeding with the preparation of radio transcriptions, which will soon be available, and which will be supplied to county societies which desire to utilize them.

In addition to these specific activities, the committee announces that it will continue to encourage business and professional groups opposed to the socialistic trend in government to join in the fight against compulsory sickness insurance.

THE CHRONICALLY ILL

ARE we thinking enough and doing enough about a problem and a duty which plagues hospitals and doctors alike? The verb "plague" is used advisedly, since any unsolved obligation will plague one until he comes to grips with it and evolves a satisfactory solution. Read the following excerpts from an article by J. H. Kinnaman in *The New York State Journal of Medicine* for March 1, 1949, and see if you think your community (and you, included) can feel satisfied that the needs of your chronically ill fellow citizens are being adequately met:

"Medicine today is as much a social as it is a biologic science. Increasingly it must organize itself to participate in community efforts in the development of sound, preventive health and medical services for all the people. Planning involves an estimate of the medical-social problems of at least the next generation.

"Widespread support is developing for several basic concepts regarding care for chronically ill persons who cannot or should not remain at home, and who do not require hospitalization. The total needs of long-term patients can be met only if homes for the aged, boarding, convalescent and nursing homes are available to them. Both tax-supported and privately owned facilities of these types are now generally insufficient to meet the demands for care outside the home and hospital. Some communities are now operating public nursing homes. Many other cities and counties are planning such facilities. Those planners should consider the effect of an aging population on the need for nursing home care. Barring wars, life expectancy is certain to lengthen appreciably in the future. This means that persons forty-five years of age and over will comprise an increasingly larger proportion of the total population. The prevalence of chronic disease becomes greater as a population ages.

"To make an effective and necessary contribution to the general medical care program of a community, all types of 'between the home and hospital' facilities should meet minimum standards, be regularly inspected, serve the total needs of the persons in them, and conserve the financial resources of patrons by basing charges on services actually required at a given time."

If "long-term" patients who need more care than can be provided at home, yet do not require elaborate facilities, could all be placed in institutions planned especially for them, just that much of the "load" would be lifted from our general hospitals. This would give much more relief than the actual number of beds involved, since the turnover in acute cases is so much faster. At the rate of ten days per patient, one bed occupied by a senile patient for a year would take care of 36 ordinary cases.

Such figures make Dr. Kinnaman's remarks worth thinking about, and it is possible that if any given County Medical Society were to think about this and if it then took the matter up with the proper local citizens, something might even be done about it. Such action could be a discomfiture to those who proclaim the medical profession to be stubbornly obstructive in its general social attitude—but then, you can't please everybody.

FRANK B. WYNN

THE American Medical Association, at its annual meeting this year, will honor Dr. Frank B. Wynn in connection with the 50th anniversary of the A.M.A.'s Scientific Exhibit.

Dr. Wynn, because of his original work in preparing the first exhibit, and because of his many years of service as chairman of the A.M.A. Committee on Scientific Exhibits, has become known as the father of the Scientific Exhibit.

Hoosier doctors may take a great deal of pride in the fact that the forerunner of the A.M.A. exhibit was one of Dr. Wynn's exhibits of pathology. The display of pathological specimens which Dr. Wynn collected for the 1898 meeting of the Indiana State Medical Association, in Lafayette, was so well received that he was invited to present it to the A.M.A. meeting in 1899.

With the aid of an appropriation by the state association, Dr. Wynn was able to amplify his exhibit and show it at Columbus, Ohio. The Scientific Exhibit has been an important part of every A.M.A. meeting ever since. Dr. Wynn served as chairman of the A.M.A. committee until 1916, and was able to develop an exhibit which today displays the advances and accomplishments of all branches of clinical and research medicine.

The 1949 Scientific Exhibit will be the 50th in a distinguished series. One of the exhibits this year will be devoted to the exhibit's own history. It is being prepared for the state association by a committee under the chairmanship of Dr. Thurman B. Rice, and will deal especially with the interesting details of early development, and with the work of Dr. Wynn.

TRAIN YOUR SALES FORCE

SPECIAL Consultant Mac F. Cahal has often said, "It is not enough for good public relations to merely tell the world that your product is better—it *must be better*." The public relations programs of the Alameda County Medical Society and the Colorado State Medical Society, to name but two, are predicated upon this proposition. They have constantly striven to improve their product, medical service; their success has been conspicuous.

Others have stated that to gain public acceptance and support, a business venture must have not only a good product and a well-planned advertising campaign, but also a well-trained and enthusiastic sales force. American physicians have today a superb product, the best medical care in the world,

based upon the system of private enterprise. By A.M.A. action they have recently been assured a well-planned and supervised campaign of public education. This leaves only the third requirement in doubt—how about medicine's sales force, the receptionists, nurses, secretaries, and technicians? Do they enthusiastically believe in American medicine and private enterprise? Have they been grounded in the fundamentals of selling, that is to say meeting and dealing with the public? These questions must receive affirmative answers or other efforts to gain public support will count for little.

Here then is where the individual radiologist, in common with most other physicians, has a problem and an opportunity. He must recognize that public opinion of a physician and of medicine through the physician are sharply affected by medical aides. These auxiliaries are in constant contact with the public; their behavior affects public reaction to both the individual and the profession which they serve. A waspish nurse or receptionist can undo the public relations value of a hundred well-treated patients. Medical assistants must be both sold on their product and founded in human relations.

To accomplish these ends it is fundamental that medical assistants understand their stake in both American medicine and the American free enterprise system. This stake should not be presented on altruistic or professional grounds, but on the basis of intelligent self-interest. Human beings are primarily interested in personal rather than social ends.

A physician owes it to his employees to point out that the only real security is that which is purchased by individual initiative and industry. It must be hammered home that security emanating from outside the individual is but disguised charity which may be withdrawn at will, leaving weakness and fear in its wake. Washington emphasized this proposition when he said, "He who seeks security through surrender of liberty loses both." These are old lessons, but valid.

In addition to this, we all occasionally need to be reminded that courtesy in human relations produces both tangible rewards and happiness. The individual can both advance himself and gain peace of mind by making friends of those whom he meets in the course of his employment. When it is stressed that these friendships have a value both intrinsic and monetary, their worth will be recognized.

Opposition to a socialized system of distributing medical care must be expressed by a demonstration of the value of the present system. This must be accomplished in the thousands of medical shop-windows, doctor's offices, over the nation. Here is where the product is displayed and the sales made. The courteous and enthusiastic rendering of service by the sales force will win public support and assure the success of the enterprise.—*American College of Radiology Monthly News Letter.*

Editorial Notes

The January 1949 issue of *The American Journal of Clinical Pathology* carries a testimonial of appreciation by the American Society of Clinical Pathologists for the many years of service which Dr. A. S. "Jerry" Giordano has rendered that organization. Jerry has been incapacitated recently, and has found it necessary to resign his position of secretary-treasurer of the Society of Clinical Pathologists.

He has also, for many years, been active in the Indiana State Medical Association, and it is a pleasure to find that he is appreciated by his fellow pathologists, as he is by the members of the state association for his work in our behalf.

Life Insurance companies of the United States and Canada will contribute \$680,000 during the coming year for the support of heart disease research, it was announced by M. Albert Linton, chairman of the Life Insurance Medical Research Fund and president of the Provident Mutual Life Insurance Company of Philadelphia, Pennsylvania. The awards raise to more than \$2,500,000 the amount contributed by the companies since the fund was started late in 1945.

A total of \$585,300 of the funds awarded today will be used as grants-in-aid by a group of 35 universities and research centers in the United States and Canada for the support of some 53 different research projects being carried on by individuals or by groups of investigators. All of this research is designed to provide basic information about the nature and causes of various forms of heart disease; some represents the continuation of work begun under the fund's support in previous years.

Organized late in 1945, the Life Insurance Medical Research Fund is now supported by 147 life insurance companies in the United States and Canada and to date has distributed \$2,575,000 for grants-in-aid and fellowships.

President's Page

A NATIONAL BOARD TO EXAMINE ALL PHYSICIANS IN 1949

MANY physicians do not realize that they are to be examined at frequent intervals during 1949 by a new examining board. This board is national in scope and will examine every doctor engaged in the private practice of medicine.

YOU HAVE LITTLE TIME TO PREPARE

You will not be notified of the time or place of the examination. Any day you may expect one or more examiners to walk into your office or home, or you may be interviewed in the hospital, at your club, or on the street. You will not be able to study the questions or evade the examination.

YOU MUST KNOW THE ANSWERS

This new examining board does not come from the A.M.A., your state association, Washington, or Moscow. It is the All-American Board and John Q. Public is the chairman. It has millions of field examiners, consisting mostly of our patients.

They mean business and are out to learn the facts about proposed socialized medicine, present and future American medical practice, and the merits and demerits of compulsory versus volunteer medical care.

They are not particularly concerned about your personal dislike for socialistic or compulsory medicine, or what it will do to the doctors, so it seems best to leave these things out of our answers.

Health and medical care are no longer a secret ritual, known only to the doctor. It is probably the most widely discussed issue before the American public today, and we doctors are in for a lot of questioning.

DO YOU KNOW THE ANSWERS?

Are you able to dissect anatomically the gaudily painted body of socialized medicine and show the malignant and infectious structures that lie beneath its skin? Or do you just know that it stinks?

You will be asked many times to do this, and you will also be asked to dissect the Twelve Point Program of Scientific American Medicine and explain it in words that all will understand. Last, but not least, your local examining board will want to know what you and your county medical society are doing on the home front.

YOU HAVE THE ANSWERS

Here in Indiana many county medical societies have adopted and are publicizing a local program of medical service. Many others will follow. These plans assure the community that competent medical care will be available at all times. It places no additional work or restriction on the doctor and in most counties has been a simple matter of coordination of the time and services of the local physicians.

The educational program of the A.M.A., sponsored by your response to the voluntary assessment, will provide you with all the answers to the national question of medical care and enable you to dissect socialized medicine.

This valuable armament is being sent direct to you through the facilities of the Indiana State Medical Association.

If you fail to study this informative data and do not follow through on your part of the program, you will be tossing your own money into the wastebasket, laying a fire under your own house, and jeopardizing freedom in America.

YOU ARE THE ANSWER

Augustus P. Haus

Medical Panorama *by the* ASSOCIATE EDITOR

IDEAS FROM M.D.'s SOUTH OF THE M.-D. LINE

That southern doctors do not spend all their time drinking mint juleps and sazeracs—and if they do, that something stimulates their thinking—is shown by an editorial in *The New Orleans Medical and Surgical Journal* for March, 1949. This is so well written it is difficult to cut and must be quoted at some length:

"THE IMPACT OF STATE MEDICINE ON THE PATIENT"

"The fact that the doctor feels an antagonism to being regimented is a novel and interesting concept to the patient but arouses no aggressive attitude in the patient.

"Three places where the problem bears on the patient should be rubbed until they shine.

"First, State Medicine will not be free. The cost will be met by an additional tax of 2 per cent or more on income paid both by employer and employees. As the actual expense is much more than the official estimates, this will soon be a 5 or 6 per cent tax on each. The first six months in England cost approximately 60 per cent more than was provided in the plan. That portion paid by the employer must still come out of earnings, or the firm could not remain solvent. We may anticipate then a 10 per cent tax on earnings. Dependable figures show that at present 4½ per cent of the family income goes to pay for medical care. The result, therefore, will be that free medicine under these conditions, without regard to quality, will cost the average family with an income of \$3600 a year about \$360, while now it costs \$180. In New Zealand, where political medicine was set up less than ten years ago, the expense today absorbs 40 per cent of all revenues collected by the government, and deficit financing has been resorted to in a desperate attempt to furnish the benefits promised. Forty per cent of the comparable revenues of the United States would exceed \$15,000,000,000 a year!

"The second place where this Utopian planning rubs the patient is explained by Lenin's statement that in any Socialistic state socialized medicine is the keystone of the Communistic arch. There are now 15,830,899 persons paid each month by the Federal Treasury. Compulsory insurance will require 1 clerk for each 100 insured, or 1,400,000 bureaucrats. That means 17,500,000 votes on the Federal payroll. The winning party in the November 1948 election needed only 24,000,000. In such a situation State Medicine under any name would be an easy preliminary to nationalization of banks, utilities, mines, and transportation.

"The third and most important aspect to present to the patient is the fact that socialized medicine will produce stagnation in the system that has made American medicine the best there is.

"When the politician intervenes, the doctor-patient relationship suffers. When the incentive to do good medicine is removed, service becomes perfunctory, cold, and unadjusted to the individual. When alertness, consideration, and initiative are subordinated to routine the delicate flower of medicine withers."

Brother Hoosier, could you say it any better yourself?

D. P. PHYSICIANS

The problem of medical licensure of medical graduates from foreign countries is well presented in the February, 1949, issue of *Minnesota Medicine*. In addition to a factual article on the background of this whole matter, there is an excellent editorial, excerpts from which follow:

"Considerable newspaper publicity has been given to the disappointment of two physicians (displaced persons) who had come to this country from Europe, one to a locality in Wisconsin and another to Minnesota, expecting to practice medicine in these new locations. The unfortunate plight of most D. P.'s is deplorable, and the disappointment of these two physicians naturally appeals to the sympathy of true Americans. The unfortunate occurrence has led certain newspapers to play it up as a sob story and point the finger of blame at the medical profession—to the undoubted delight of those unfriendly to the profession.

"Laws regarding the licensing of physicians differ in the different states. In some states licensing is controlled by regulations passed by the Boards of Medical Examiners. Some states require full citizenship; others require first papers; some require a year of internship in a hospital within the state; many require credentials as to medical education which are often impossible to obtain. Our boards have no way of ascertaining the worth of some credentials which have been presented by D. P.'s and in some instances those presented have proven bogus.

"Medical education in certain European countries has been in a deplorable state during the past decade. Under the Nazi regime, numbers rather than quality was the objective. How can a board judge the qualifications of a physician trained in Russia? The same applies to Poland. Austrian medicine, which not so long ago represented the acme of medical training, has had no opportunity to keep abreast of the outstanding advances in therapeutics such as the use of the antibiotics.

"It is said that some 6,000 D. P. physicians have entered the United States up to 1942, 3,500 of whom have been licensed. The greatest influx has been in the eastern states, notably New York and Massachusetts. Many State Boards have considered the state of D. P. physicians with much sympathy and have permitted applicants to take and retake examinations repeatedly. Actually it is much easier for a D. P. physician to obtain a license to practice in this country than for an American physician to be licensed in most foreign countries."

Dr. Irving S. Wright, of Cornell University Medical College, reported in 1948 a survey of medical education in Germany and Austria, made in 1947 under the auspices of the Surgeon General of the U. S. A., his summary being as follows:

"Medical education in Germany is at an extremely low level at this time. The Universities of Heidelberg and Wurzburg are the most satisfactory. Medical education in Vienna is somewhat better, but is handicapped by overcrowding. . . . *Students graduating from these schools have not received a medical education comparable with that obtained in medical schools in this country.* This situation should be subjected to continuing analysis and recording by the boards of licensure so that in the future graduates from these schools who apply for license to practice in the United States may be properly evaluated."

HELPFUL INSTRUMENTS FROM OTHER FIELDS

FRANKLIN E. HAGIE, M.D.

RICHMOND

IN THE practice of surgery through the years I have adopted certain common instruments used in other fields, to try to make our surgical work more easy and convenient. Surgery is mechanical work and the instruments we use often are developed in machine shops. Many surgeons have a machine or wood shop in the basement of their home, as I have, and use it as a hobby. From using motor and hand tools in such a layout, ideas come in working with metal or wood which later are incorporated in the surgical field. In this paper I mention a few ideas along this line relative to surgery, to stimulate us all in trying to make our work more easy.

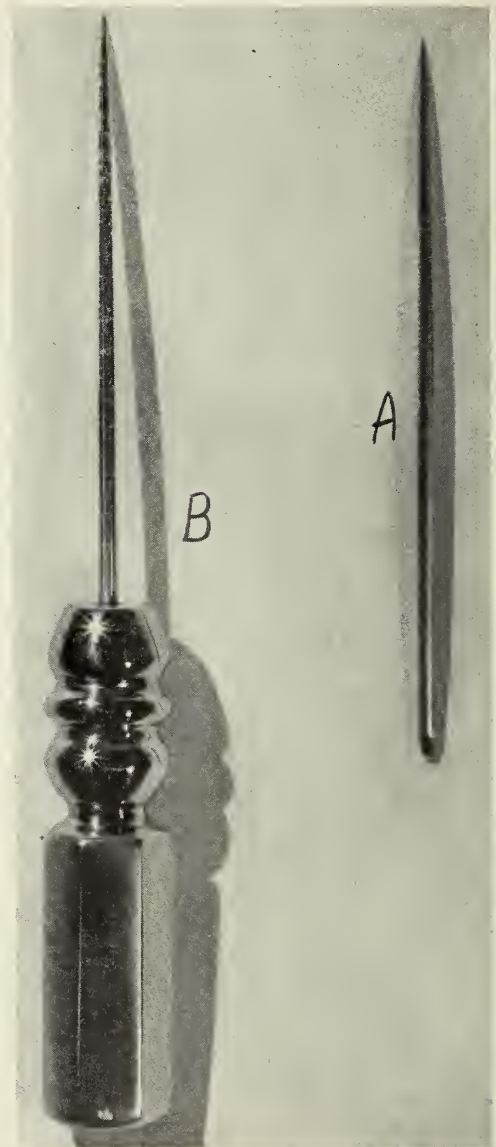
1. *The ice pick* I have used for years in bone surgery. The idea came to me when I experienced difficulty in raising a depressed skull fracture. I had nothing among my surgical instruments to start the raising process so found a metal handled ice pick, which had been left at our home in the days of ice refrigerators, to be most convenient. In certain types of forearm fractures ice pick punctures help greatly in securing proper reduction. Any ice firm will be glad to give you an ice pick of fine tempered steel with a wooden handle. Pull the pick A of Figure 1 out of the wooden handle and insert it into a steel handle, which can easily be ground out of metal, as shown in B of Figure 1. Then have it chrome plated and you have a very useful instrument in bone surgery.

2. *The Jacobs Chuck* I fitted on my surgical hand drills long before they were put on the market by surgical houses. I had Jacobs chucks on my electric hand drills and drill presses in my machine room at home, and because of their convenience put them on my surgical drills at the hospital. I simply had adopted what was being used in machine shops.

3. *The magnet*, as shown in Figure 2, is handy in surgery in picking up Bard Parker blades and needles from sterilizing fluids. Years ago I purchased a magnet from a ten cent store, filed off the red paint and then had it plated. On account of its convenience, I had an instrument house put a handle on one, as shown in the cut.

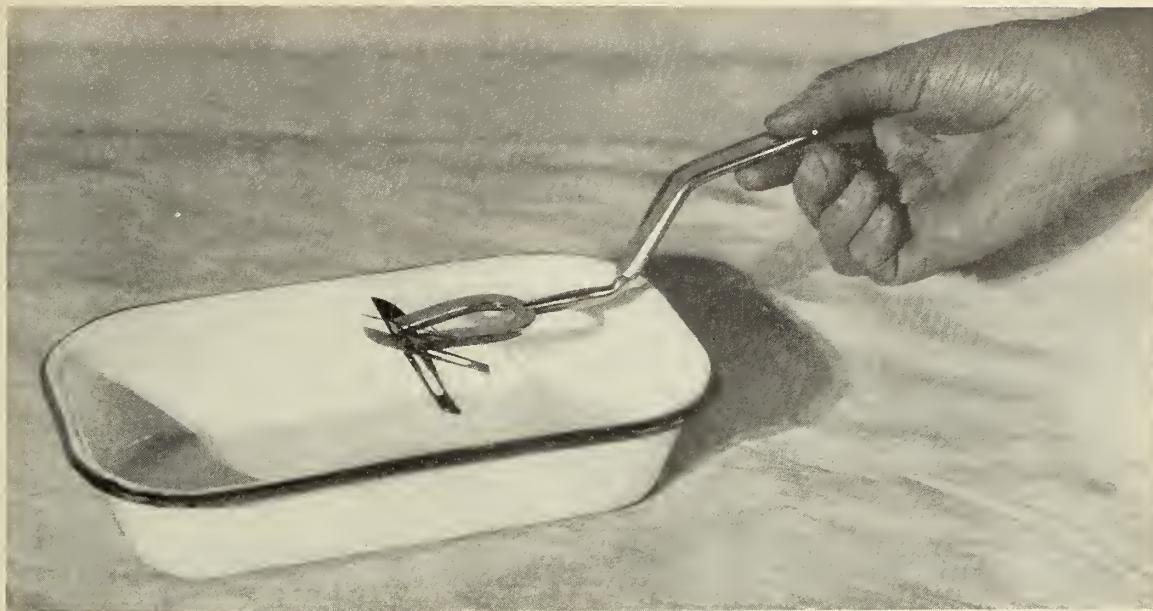
4. *The sand glass* over the scrubbing sink is much better than any clock to time one in scrubbing. At first I was able to get only the three and five minute sand glasses used for timing eggs, as they were the only ones available, but lately the ten minute glass is on the market. This is used every day at our hospital and it is very convenient for nurses and doctors to turn it over at the start of washing hands and arms before surgery.

Figure 1



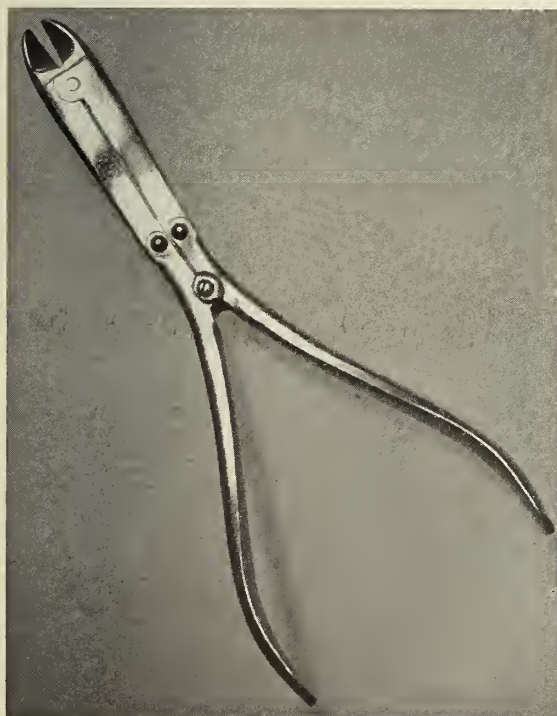
5. *The Cobblers Nipper*, as shown in Figure 3, is convenient in the cutting of wire or the cutting of pins used in the care of neck fractures of the hip. The ordinary type of cutter on the market, on account of the wide jaws, makes it difficult at times to get near enough to the nut to cut the pin, due to the other pin insertions. This double action cutter meets every requirement more easily because of its shape than any surgical cutter we have. In Figure 4 one may see how readily and easily it meets the situation for cutting the pin.

Figure 2



6. *The Grab All Tool*, or mechanical hand, as shown in Figure 5, is used by garage men to pick up articles in difficult places about cars. With its flexible shaft, I have pushed it up the common hepatic duct, to remove difficult gallstones. A gallstone is shown in the claw of one in the cut.

Figure 3

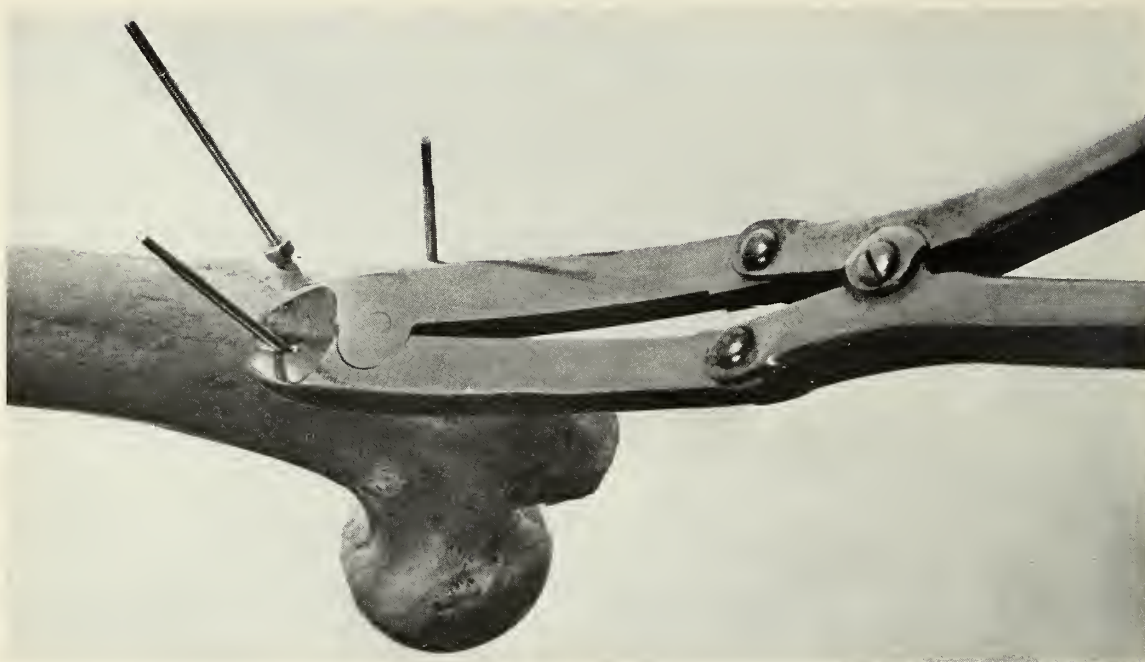


The instrument may be used in other fields of surgery.

7. *The Single Claw Hook*, as shown in Figure 6, I had made a number of years ago, to simplify the operation of a complete hysterectomy. The hook is 10 inches in length and I have two in a hysterectomy set. With the cervix dissected down and the vagina opened, the hook is caught in the face of the cervix, turning it up into view so that one can more easily trim the cervix loose from the vaginal wall. By this method one gets very little, if any, shortening of the vaginal canal. I first used long, single tenaculums which gave me the idea of the hook, and the cervical hook has turned a complete hysterectomy into a much more easy procedure.

8. *The Samson Lever Jaw Wrench*, as shown in Figure 7, has been put on sale at hardware stores during the last few years. Many instruments have been manufactured to hold and manipulate long bones in open fracture reductions. To hold the bone there is a lock or ratchet at the end of the handles which is always in the way. This jaw wrench, as shown in the cut, is a most convenient bone holding forceps. The screw A in Figure 7 sets the size of the bite desired, which is just a little smaller than the diameter of the bone to be held. Then, clamping the handles together, a fixed, firm hold of the bone may be had, and the reduction may be made easily with a clamp on each fragment, as shown in Figure 8. The cost is approximately two dollars, and a pair as shown can be plated, and will make a far better and more

Figure 4



convenient bone forceps than any on the market today. They will be adopted later in our bone instruments, as the principle is right.

9. *The Sherman screws* used to anchor plates for internal fixation of fractures measure .143

inches in diameter over threads. The core of the screw is .116 inches in diameter, and as the screw is a tap for the hole, the size of the drill to be used should be the size of the core of the screw, or .116 inches. The drills sent out by the instrument

Figure 5



Figure 6



Figure 7

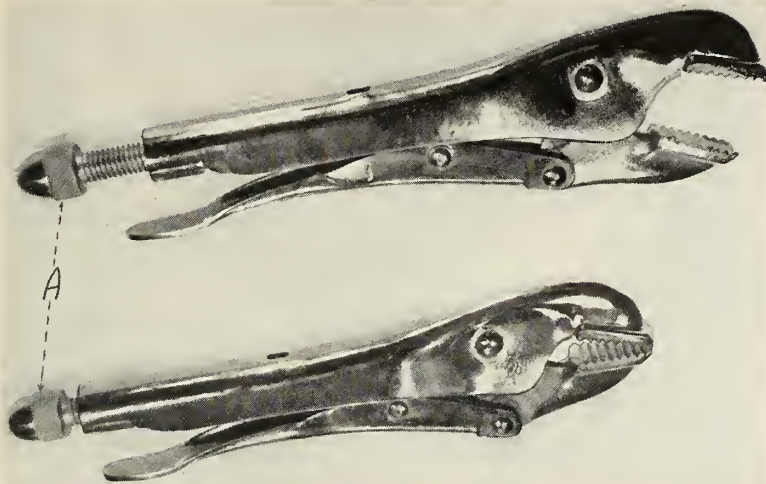


Figure 8

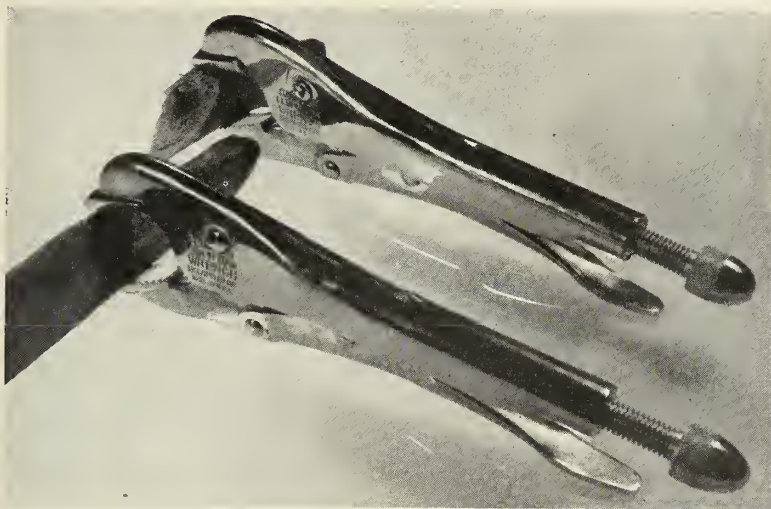
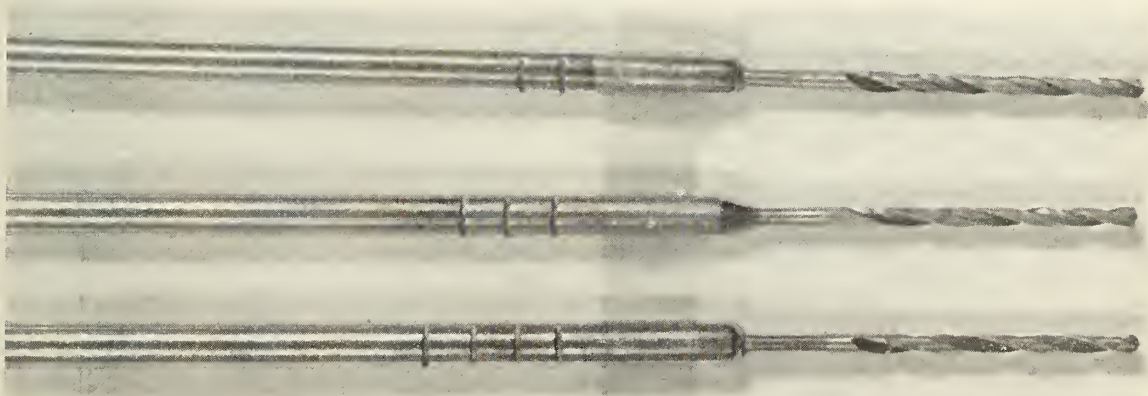


Figure 9



houses are $\frac{1}{8}$ or .125 inches in diameter, and $\frac{7}{64}$ or .109 inches in diameter. One is too large and you get very little tap effect and a loose screw, and the other is too small and the screw cannot be started. You have to discard your fractional inch drills and go to your wire gauge number drill set from #1 to #60. From this set you have three drills available: #32 is .116, #33 is .113, and #34 is .111 inches in diameter. You can use #32, #33, or #34, but to get a firm hold I more often use #34 drill. When I use a plate for internal fixation or a plate and lag screw for intertrochanteric femur fractures, I have the three drills, as shown in Figure 9, with a six inch extension. The extension is of quarter-inch steel and I set the drill in a half inch drill hole in the end of the shaft and then weld the drill to the shaft. I have sawed cross lines on each shaft, 2, 3, and 4 lines, as shown in the picture, to correspond to #32, #33, and #34 respectively. In this way you can quickly determine which drill you have or want to use. The object of the extension is so as to take the bone motor farther out of the field when drilling. This is especially helpful in work on hip fractures.

In this article I have reviewed a few conveniences which I have adopted in surgery in the hope that they might be helpful, useful, and of interest.

SOME SOURCES OF MATERIAL RELATIVE TO SOCIALIZED MEDICINE AND COMPULSORY SICKNESS INSURANCE*

1. Indiana State Medical Association,
1017 Hume Mansur Building,
Indianapolis 4, Indiana.
 2. Wemple Dodds, M.D.,
Chairman of Committee on Public Relations,
Indiana State Medical Association,
Culver Hospital Laboratories,
Crawfordsville, Indiana.
 3. Blue Cross Hospital Service,
54 Monument Circle,
Indianapolis 4, Indiana.
 4. Association of American Physicians and Surgeons, Inc.,
360 North Michigan Avenue,
Chicago 1, Illinois.
 5. The National Physicians Committee,
75 E. Wacker Drive,
Chicago, Illinois.
 6. Council on Medical Service,
American Medical Association,
535 N. Dearborn Street,
Chicago 10, Illinois.
 7. The Shearon Medical Legislative Service,
610 Columbian Bldg.,
416 Fifth Street, N.W.,
Washington 1, D. C.
- These are some of the authorities which will assist with advice and material of various kinds when requested to aid in preparing addresses, radio talks, debates, newspaper publicity, and so on, in the discussion of socialized medicine, compulsory sickness insurance, et cetera.
- The following is a list of a few of the bibliographic references which may be helpful as sources of material for those interested in gathering information on Socialized Medicine, Government Medicine, Compulsory Insurance, Modern Medical Care, and other matters which may be useful in preparing talks or other publicity materials.
1. A suggested list of reading material supplied by the Association of American Physicians and Surgeons, Inc.

This is the reading material suggested for those who are taking part in the Third Annual Essay Contest for students in Junior or Senior High Schools on the subject "Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care."
 2. THE CASE AGAINST SOCIALIZED MEDICINE, by Lawrence Sullivan,
Published by the Statesman Press, National Press Building,
Washington 4, D. C.
This is a MUST for anyone who is going to make a speech against socialized medicine. Every physician, and every physician's wife should read this and use the information contained.
 3. UNCLE SAM . . . M.D.
• A brochure prepared by the Michigan Public Expenditure Survey, 820 Farwell Building, Detroit 26, Michigan.
 4. Socialism, a Politician's Paradise, (talk number 314) by Henry J. Taylor.
c/o General Motors,
Detroit 2, Michigan.
 5. Dan Gilbert's Washington Letter,
December, 1948.
• 511 Eleventh Street, N.W.,
Washington 4, D.C.
This is a useful approach to assist a minister in preparing a sermon against socialized medicine.
 6. Compulsory Sickness Insurance and Nationalization of Medicine,
Chicago Medical Society Bulletin,
January 29, 1949.
This is a good "for-and-against" article.
 7. The Camel's Nose,
The Bulletin of Hanover College, February, 1949.
Hanover College, Hanover, Indiana.
This is excellent background material for any discussion of socialized medicine.
 8. Socialized Medicine—Bad Medicine for You, by Michael Wright,
Better Homes and Gardens, January, 1947.
Sometimes these "popular" articles are useful in giving a laymans' slant which may be helpful in putting over a talk with a difficult group.
 9. Will Compulsory Insurance Help Keep You Healthy?
Yes! says Albert Deutsch.
No! says Greer Williams.
Better Homes and Gardens, September, 1948.
This is a good "for-and-against" article. Such articles are especially useful in preparing for debates.

* Compiled by Lall G. Montgomery, M.D., Muncie, Indiana.

10. Doctor, My Statistics Feel Funny!
by Maurice Friedman, M.D.,
Nation's Business, May 1948.
Also digested in Reader's Digest, August, 1948.
This is a MUST for anyone who is trying to combat the pernicious type of propaganda based on the statistics relative to the health status of the draftees for the armed forces in the past war.
 11. The Doctors Run the Show,
by Bill Davidson,
Collier's, May 11, 1946.
This is a popularized version of the "Michigan Plan."
 12. Compulsion. The Key to COLLECTIVISM,
Published by The National Physicians Committee,
75 East Wacker Drive,
Chicago, Illinois.
This 192-page book contains a tremendous amount of material which will be useful to those who have time to read detailed discussions.
 13. Voluntary Health Insurance vs. Compulsory Sickness Insurance,
Council on Medical Service,
American Medical Association, 1946.
535 North Dearborn Street,
Chicago 10, Illinois.
This is a very useful compilation of a number of articles from various sources.
 14. Our Most Dangerous Lobby—I
by Forest A. Harness,
Reader's Digest, September, 1947.
 15. Our Most Dangerous Lobby—II
by Forest A. Harness,
Reader's Digest, December, 1947.
These two items (14 and 15) are particularly useful if speaking to groups who are "political minded."
 16. The Responsibility for Medical Care,
by Paul R. Hawley, M.D.,
Hospital Progress, August, 1948.
 17. More Security for *YOU*.
by Oscar R. Ewing, Federal Security Administrator,
The American Magazine, January, 1949.
This is a typical article by the chief proponent of National Compulsory Government Health Insurance.
An article or two of this type should be part of the background for any discussion of Socialized Medicine. This is typically filled with garbled and distorted facts and figures which are being used constantly by those who wish to convince the American Public of the desirability of socialization of medicine.
 18. Medical Care for the Individual.
A statement of the issues and conclusions from a study by the Brookings Institute, obtainable from the American Medical Association, Suite 301—1302 18th Street, N.W., Washington 6, D. C.
 19. Blueprint for the Nationalization of Medicine,
by Marjorie Shearon,
The Shearon Medical Legislative Service,
610 Columbian Bldg.,
416 Fifth St., N.W.,
Washington 1, D. C.
 20. Blue Shield, or Compulsory Government Insurance,
by Paul R. Hawley, M.D.,
Associated Medical Care Plans,
The National Association of Blue Shield Plans,
330 South Wells Street,
Chicago 6, Illinois.
 21. Private Enterprise or Government Medicine,
by Louis Hopewell Bauer, M.D.,
Published by Charles C. Thomas, Springfield, Illinois.
This is for the serious student who wants to go into details for himself. A well documented and scholarly book.
 22. The Issue of Compulsory Health Insurance,
by George W. Bachman and Lewis Meriam,
The Brookings Institution,
Washington 6, D. C.
This is a most important document in the field which was prepared at the request of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare.
- This is obviously only a partial list of the sources of information which would be helpful and useful in obtaining material for use in preparing talks or other material which might be used in combatting the campaign for the socialization or "governmentalization" of medicine. However, it is impossible for most of those who might use such information to read *all* of the vast amount that is being written and spoken, for and against the socialization of medicine, so a PARTIAL list is as much as most physicians can hope to use. Included in this bibliography are representative samples of most of the kinds of articles which have been written in the past two or three years, so this provides the type of cross section of the argument which is most useful to those who are interested. Any of the organizations mentioned in the first part of this list will be glad to assist in organizing this material and in keeping interested individuals provided with the latest and most up-to-date information.

News Notes

Irvin Scott, M.D., of Sullivan, was honored recently by the Peruvian Surgical Society, which invited him to appear on the program at its annual meeting in Lima, Peru. Doctor Scott was invited to introduce a new technique in fractures at that meeting. The invitation was made by the president of the International College of Surgeons, and in addition to his demonstrations of fracture fixations before clinics, Doctor Scott also addressed the Peruvian Surgical Congress.

As a tribute to his many years of service, a plaque was unveiled on March 16 in the obstetrical ward of General Hospital, in Indianapolis, in honor of Henry F. Beckman, M.D. He has served as head of the hospital's obstetrical staff for forty years, and was professor of obstetrics at the Indiana University School of Medicine.

M. B. Gossard, M.D., formerly of Kempton, opened an office in Tipton recently for the general practice of medicine. A graduate of Indiana University School of Medicine in 1939, Doctor Gossard interned at St. Vincent's Hospital, in Indianapolis before entering the U. S. Army Medical Corps, in which he served for six years. Following his discharge from the Army, Doctor Gossard took post-graduate work and a residency in obstetrics at the Coleman Hospital, in Indianapolis, and then established an office in Vincennes, where he was associated with Dr. Frederick Spencer, until opening his office in Tipton.

A. David McKinley, M.D., has been appointed assistant medical director of the Indiana University Medical Center hospitals. A native of Muncie, Doctor McKinley graduated from the Indiana University School of Medicine in 1939, and had practiced in Speedway City for two years before entering the service.

Announcement has been made of the opening of an office at 4036 Wilshire Boulevard in Los Angeles, California, by Emile M. Ravdin, M.D., a 1942 graduate of the Indiana University School of Medicine. Following his internship at the Indiana University Medical Center, Doctor Ravdin spent three years in the U. S. Army Medical Corps, and then took a Basic Science Course in ophthalmology at Northwestern University, followed by a residency at Wills Eye Hospital in Philadelphia. He is limiting his practice to ophthalmology.

COMING MEDICAL MEETINGS

Indiana State Medical Association, Indianapolis, September 26, 27, 28, 29, 1949.

American Medical Association, Annual Session, Atlantic City, June 6, 7, 8, 9, 10, 1949.

American Association of Genito-Urinary Surgeons, White Sulphur Springs, W. Va., Greenbrier Hotel, May 9-11. Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secretary.

American Association of the History of Medicine, Lexington, Ky., May 23-24. Dr. Benjamin Spector, 416 Huntington Ave., Boston 15, Secretary.

American Congress of Physical Medicine, Netherland Plaza, Cincinnati, September 6, 7, 8, 9, 10, 1949.

American Goiter Association, Madison, Wisconsin, May 27, 28, 1949. Dr. T. C. Davison, Atlanta, Georgia.

American Dermatological Association, Hot Springs, Va., May 23-26. Dr. Louis A. Brunsting, 102 Second Ave. S.W., Rochester, Minn., Secretary.

American Gastro-Enterological Assn., Atlantic City, Claridge Hotel, June 3-4. Dwight L. Wilbur, M.D., 655 Sutter St., San Francisco 2, Secretary.

American Goiter Association, Madison, Wis., Hotel Loraine, May 26-28. Dr. Thomas C. Davison, 478 Peachtree St., N.E., Atlanta 3, Ga., Secretary.

American Laryngological Association, New York, May 16-17. Dr. Louis H. Clerf, 1530 Locust St., Philadelphia, Secretary.

American Ophthalmological Society, Hot Springs, Va., The Homestead, June 2-4. Maynard C. Wheeler, M.D., 30 W. 59th St., New York, Secretary.

American Orthopedic Association, Colorado Springs, May 18-21. Dr. C. Leslie Mitchell, Henry Ford Hospital, Detroit 2, Secretary.

American Otological Society, New York, May 18-19. Dr. Gordon D. Hoople, 713 E. Genesee St., Syracuse, N.Y., Secretary.

American Pediatric Society, Atlantic City, May 5-6. Dr. Henry G. Poncher, 1819 W. Polk St., Chicago 12, Secretary.

American Proctologic Society, Columbus, Ohio, May 31-June 4. W. Wendell Green, M.D., 1838 Parkwood Ave., Toledo, Ohio, Secretary.

American Psychiatric Association, Montreal, Canada, May 23-27. Dr. Leo H. Bartemeier, General Motors Bldg., Detroit 2, Secretary.

American Society for Clinical Investigation, Atlantic City, May 2. Dr. Paul B. Beeson, Grady Hospital, Atlanta 3, Georgia, Secretary.

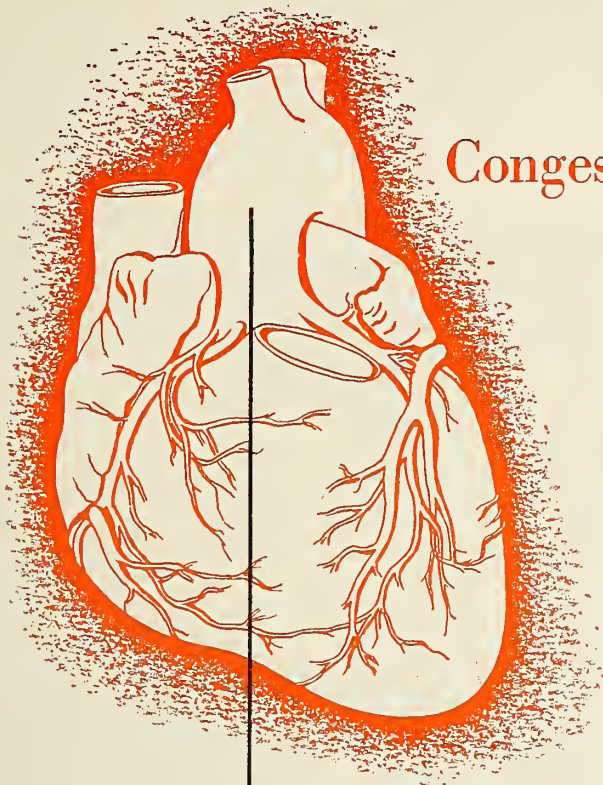
American Society for the Study of Sterility, Atlantic City, N. J., June 6 and 7, 1949. W. W. Williams, M.D., Secretary, 20 Magnolia Ter., Springfield, Mass.

American Therapeutic Society, Atlantic City, June 2-5. Oscar B. Hunter, M.D., 915 Nineteenth St., N.W., Washington, D. C., Secretary.

International Congress on Rheumatic Diseases, Waldorf Astoria, New York City, May 30-June 3, 1949. Dr. Ralph Pemberton, 1901 Walnut St., Philadelphia 3.

Society of American Bacteriologists, Cincinnati, May 15-20. Dr. John Blair, Hospital for Joint Diseases, New York, Secretary.

Southeastern Surgical Congress, Biloxi, Miss., May 23-26. Dr. Benjamin T. Beasley, 45 Edgewood Ave. S.E., Atlanta 3, Ga., Secretary.



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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

Patronize Your Advertisers

John A. Larson, M.D., native of Shelbourne, Nova Scotia, Canada, has assumed his duties as superintendent of the Logansport State Hospital. For the past two years he has been superintendent of the Arizona State Hospital. Doctor Larson is a graduate of Rush Medical College, Chicago, in 1928, and has been criminologist for the state of Illinois and a psychiatrist at Iowa State Psychopathic Hospital, in Iowa City.

William A. Shuck, M.D., a 1932 graduate of the Indiana University School of Medicine, has opened an office at 3311 N. Meridian Street, in Indianapolis, for the practice of general surgery. Doctor Shuck spent his internship at the Methodist Hospital in Indianapolis, and then practiced medicine and surgery at Madison from 1933 until 1942. He spent forty-two months in the Army, where he was on the surgical service of the 54th General Hospital. He spent twenty-two months in the Southwest Pacific area, as chief of the surgical section. He was discharged from the service in December 1945, with the rank of major, following which he took twenty-six months of postgraduate training in general and thoracic surgery in New Orleans, Louisiana.

Announcement has been made of the marriage of Miss Virginia Lee Carroll, of Knightstown, and **John L. Shively, M.D.**, formerly of Muncie. The ceremony was performed on March 6 at the Bethel Presbyterian Church in Knightstown. Doctor Shively is a graduate of the Indiana University School of Medicine, and has opened an office for the practice of medicine in Hagerstown, where the couple will reside.

Lloyd Terry, M.D., a native of Coatesville, has become associated in the practice of medicine with Dr. M. E. Frantz, at Danville. Doctor Terry is a graduate of Indiana University School of Medicine, and has been a member of the staff at Billings Hospital, in Indianapolis.

An Ohio Camp for Diabetic Children

Camp Ho Mita Koda is situated near Newbury, Ohio, about twenty-five miles east of Cleveland. It will operate during 1949 for two periods of one month each beginning June 26. Boys and girls between the ages of six and sixteen years are accepted. Camp activities include swimming, hiking, nature study, handicrafts, group singing and plays.

The standard fee is \$150 per month. Funds have been donated which can be used to help a few children whose parents cannot pay the full fee. The camp is a nonprofit organization under the direction of a Board of Trustees composed of prominent citizens of Cleveland and a director appointed by them. The camp is staffed with a resident, licensed physician, nurses and dietitians. The medical director is E. Perry McCullagh, M.D.,

All inquiries should be sent to Mr. Byron Williams, Director, Camp Ho Mita Koda, R.F.D. 2, Chagrin Falls, Ohio.

Announcement has been made of the appointment of the following physicians to the Indiana State Board of Health: **Harry Ross, M.D.**, of Richmond; **Russell Lavengood, M.D.**, of Marion; and **Jacob T. Oliphant, M.D.**, of Farmersburg. At the meeting of the Board on March 9, Doctor Oliphant was named chairman and **Dr. L. E. Burney** was reappointed secretary.

The following five physicians were elected to three year terms on the board of directors of Mutual Medical Insurance, Inc.: **Drs. C. J. Clark** and **A. F. Weyerbacher**, of Indianapolis; **Wemple Dodds**, Crawfordsville; **Charles Overpeck**, Greensburg; and **G. O. Larson**, LaPorte. These physicians comprise the Indiana State Medical Association's representatives on the board.

ARMED FORCES MEDICAL SERVICE

A direct appeal is now being made to the 8,000 young physicians and dentists who were trained at government expense under the wartime Army Specialized Training Program and the Navy V-12 program, and who have given little or no service to the Armed Forces, to volunteer for active duty in one of the three Armed Services.

An appeal is also being directed to the 7,000 physicians and dentists who were deferred during the war to complete their medical or dental educations at their own expense, and who have not served in the Armed Forces, to volunteer for active duty.

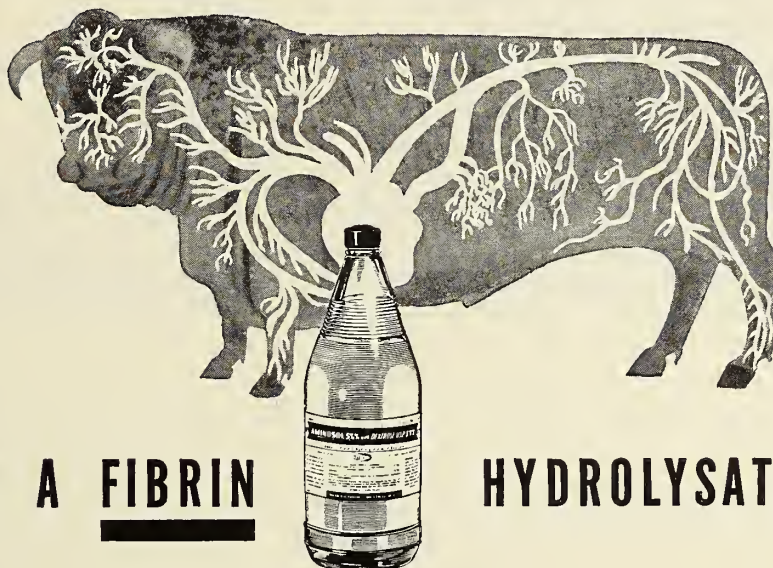
This program is a joint undertaking of the three Services, the American Medical Association, the American Dental Association, and other allied professional groups to fill the critical professional manpower shortage which faces the Armed Forces.

Should a shortage of professional manpower be allowed to materialize it could easily jeopardize the whole National Defense Program. It would mean the Armed Forces would not have enough physicians and dentists to furnish even a minimum of medical and dental service to the nearly 2,000,000 men and women in the military Services.

It is estimated that the government expended almost \$10,000,000 to educate, feed and clothe the 8,000 men who participated in the wartime programs.

If the present campaign for volunteers is unsuccessful, consideration must be given to the following alternatives:

- (1) To ask for draft legislation covering physicians and dentists who have not responded to the call for volunteers.
- (2) To ask those men who served in World War II, and who hold reserve commissions, to re-enter for active duty in the Armed Forces.
- (3) To retain those men now on duty, but who are entitled to be relieved from the service upon completion of their respective tours of duty, until the shortage has been corrected.



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1. Christensen, H. N., Lynch, E. L., Decker, D. G., and Powers, J. H. (1947), The Conjugated, Non-Protein, Amino Acids of Plasma.
 IV. A Difference in the Utilization of the Peptides of Hydrolysates of Fibrin and Casein, J. Clin. Invest., 26:849, September.

Dr. Melvin D. Price, of Nappanee, received the tribute of being named honorary town citizen of the month. He was presented with a jeweled pin in recognition of his thirty-eight years of the practice of medicine in Nappanee.

ARMY ANNOUNCES OPENING OF VALLEY FORGE HOSPITAL TO GRADUATE PROFESSIONAL EDUCATION PROGRAM

Beginning July 1, 1949, Valley Forge Army General Hospital, Phoenixville, Pennsylvania, will participate in the Graduate Professional Education Program, it was announced recently by Major General R. W. Bliss, The Surgeon General. This will bring the number of general hospitals participating in this program to nine, and will open a new source of training to young physicians interested in the Army Military Intern Program. The Army has extended an invitation to medical students to visit its training hospitals during the summer months.

The Military Intern Program offers graduate professional training opportunities to selected graduates of medical schools approved by the American Medical Association. Successful candidates are assigned to Army general hospitals which have a great variety of clinical material. All participating hospitals are approved for such teaching by the Council on Medical Education and Hospitals of the American Medical Association.

MEDICAL MOTION PICTURE

A new film, titled "Cancer: The Problem of Early Diagnosis," which has received the approval of the American Medical Association's Committee on Medical Motion Pictures, was made available to the medical profession recently through more than 50 state and regional distributing points.

The film is co-sponsored by the American Cancer Society and the National Cancer Institute of the United States Public Health Service. Prints for single showings may be borrowed from the Indiana Cancer Society, 325 Board of Trade Building, Indianapolis; or from the Indiana State Board of Health, Indianapolis.

The film consists of one reel, 16 mm., color, sound, 1,200 feet, showing time thirty minutes. "Cancer: The Problem of Early Diagnosis," is the first in a series of six films to deal with the subject. The succeeding five, to be released within the

next two years, will deal with diagnosis of cancer by specific body site.

The film was reviewed in the January 29th issue of the A.M.A. Journal. The comment was: "The photography, animation and narration are excellent."

Announcement was made at the Annual Convocation of the American College of Physicians on March 30 of the election of eight Indiana physicians to Fellowship in the College. To be eligible for Fellowship, a physician must have been graduated from an approved medical school, serve three years as an associate in the College, and if engaged in practice, his professional activity must be limited to internal medicine.

Physicians from Indiana thus honored were: Dr. Joseph E. Walther, Indianapolis; Dr. Donald E. Wood, Indianapolis; Dr. Stuart R. Combs, Terre Haute; Dr. Robert W. Currie, Lafayette; Dr. Harold E. Stadler, Indianapolis; Dr. Wendell A. Shullenberger, Indianapolis, Dr. Richard M. Nay, Indianapolis; and Dr. James S. Browning, Indianapolis.

Six of the physicians who were made Fellows at this Convocation were members of the 1935 class of the Indiana University School of Medicine. They were Drs. Donald E. Wood, Stuart R. Combs, Robert W. Currie, Wendell A. Shullenberger, James S. Browning, and W. H. Kammerer, who is now associated with Dr. R. L. Cecil in New York City.

W. L. Portteus, M.D., of Franklin, was re-elected Commissioner-at-large of the Blue Shield Commission, at its convention, which was held in April in Hollywood, Florida.

Franklin S. Crockett, M.D., of Lafayette, Chairman of the Rural Health Committee of the American Medical Association, closed his office on April 19, for a five month period, during which he and Mrs. Crockett will tour Italy, Switzerland, Holland, Belgium and France. Dr. Crockett plans to spend part of his European vacation observing continental medical practice and hospital conditions, in particular the influence on them of government control. The Crocketts will be back in this country on September 1.

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Michael Reese Hospital Postgraduate School announces a course on "Recent Advances In Internal Medicine," by members of the Department of Internal Medicine, of other clinical departments, and of the Division of Laboratories and Research. The course is divided into two sections, one week each, and consists of lectures and the presentation of illustrative cases. Students may register for either or both sections. May 23 to June 4, 1949, (full time). Tuition: \$100. For further information address: Dr. Samuel Soskin, Dean, Michael Reese Hospital Postgraduate School, 29th St. & Ellis Ave., Chicago 16.

The Cook County Graduate School of Medicine of Chicago has arranged two courses that will be of special interest to some of the members of the Indiana State Medical Association. A Two Weeks' Intensive Personal Course in the "Diagnosis and Treatment of Congenital Malformations of the Heart" will be offered by Benjamin M. Gasul, M.D., starting Monday, June 13. A Two Weeks' Intensive Personal Course in "Cerebral Palsy" will be offered by M. A. Perlstein, M.D., starting Monday, August 1. These physicians are Members of the Attending Staff of the Cook County Hospital.

SECOND DISTRICT

The Second Councilor District Medical Society will meet in Sullivan on June 2. The program will be held in the afternoon, followed by a dinner at night.

FIFTH DISTRICT

The Fifth Councilor District Medical Society will meet in Brazil, on Wednesday, May 25, at the Elk's Club. The scientific program will be presented in the afternoon, when the guest speakers will be: Dr. Irvin H. Scott, of Sullivan, who will speak on "External Fixation of Fractures," and Dr. Carl P. Huber, of Indianapolis, who will discuss "The Management of Labor." The evening speaker will be Dr. Warren F. Draper, of Washington, D.C., who is the medical director of the United Miner's Welfare and Benefit Association, and who will present the welfare program recently adopted by the United Mine Workers. All physicians are cordially invited to attend this meeting. A dinner will be served at 7:00 p. m.

Deaths

Carleton Buell McCulloch, M.D., of Indianapolis, died on April 5, after a short illness, at the age of seventy-eight. A graduate of the Chicago Homeopathic Medical College, in 1895, Doctor McCulloch began the practice of medicine in Indianapolis in 1897, and became one of the state's most prominent professional, civic and political leaders. He was both physician and friend to Indiana's most illustrious citizens and, because of his close relationship with James Whitcomb Riley, was an incorporator of the Riley Memorial Association and a member of the board of directors of the Riley Hospital for Children. Doctor McCulloch assisted in organizing Lilly Base Hospital



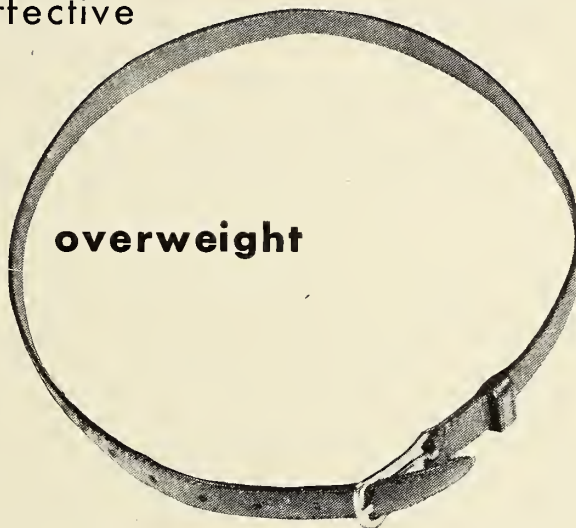
32 in World War I, in which war his service record was outstanding. After the war he became active in American Legion affairs, and took keen interest in political affairs. During the past several months he has been active in planning a Riley Centennial Research Fund, which will support research into children's diseases at the Riley Hospital. Doctor McCulloch was an Honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

George S. Greene, M.D., former Gary physician, died at the age of 73, on March 22, in Niles, Michigan. He graduated from the Detroit Medical College in 1894, and had practiced in Gary for thirty years before retiring in 1939.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 10, 1949

The Council of the Indiana State Medical Association convened for its spring meeting at 10:10 a.m., Sunday, April 10, 1949, in the Columbia Club, Indianapolis, with Dr. Alfred Ellison, chairman, presiding. Roll call showed the following present:

Councilors:

First District.....Not represented
Second District.....William C. Reed, Bloomington
Third District.....William H. Garner, New Albany
Fourth District.....George A. May, Madison
Fifth District.....A. M. Mitchell, Terre Haute
Sixth District.....W. U. Kennedy, New Castle
Seventh District.....Cyrus J. Clark, Indianapolis
Eighth District.....E. H. Clauser, Muncie
Ninth District.....Wemple Dodds, Crawfordsville
Tenth District.....William H. Howard, Hammond
Eleventh District.....Elton R. Clarke, Kokomo
Twelfth District.....Paul A. Garber, South Whitley
Thirteenth District.....Alfred Ellison, South Bend

Officers:

Augustus P. Hauss, New Albany, president.
C. S. Black, Warren, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
Frank B. Ramsey, Indianapolis, editor of THE JOURNAL.
C. H. McCaskey, Indianapolis, chairman, Executive Committee.
W. L. Portteus, Franklin, member Executive Committee.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, Indianapolis, executive secretary.

Guests:

J. Neill Garber, Indianapolis, chairman, Committee on Centennial Arrangements.
J. William Wright, Indianapolis, co-chairman, Legislative Committee.

On motion of Drs. Garber and Mitchell, the minutes of the midwinter meeting of the Council, held at Indianapolis on January 16, 1949, were approved as printed in the March, 1949, issue of THE JOURNAL.

Reports of Councilors

Reports, which were favorable in most instances, indicated that the councilors have been busy contacting the county medical societies in their districts to obtain information on the following points:

- (1) Whether or not the societies have "round-the-clock" service.
- (2) Whether or not the societies are getting favorable newspaper publicity on their medical service set-ups, and on compulsory health insurance.
- (3) Success in collection of A.M.A. assessment.
- (4) Contact with civic and community clubs regarding speeches on compulsory health insurance.
- (5) Progress of enrollment in Blue Cross-Blue Shield.
- (6) National legislative activities.

The chairman called attention to the fact that the Third, Fourth, Fifth and Ninth District meetings are scheduled for the same date, May 25, saying that this is an unfortunate situation inasmuch as the association officers cannot attend all four meetings. In order to avoid such conflicts, Dr. C. J. Clark suggested that the headquarters office send a letter to each councilor as soon as a district meeting date is reported.

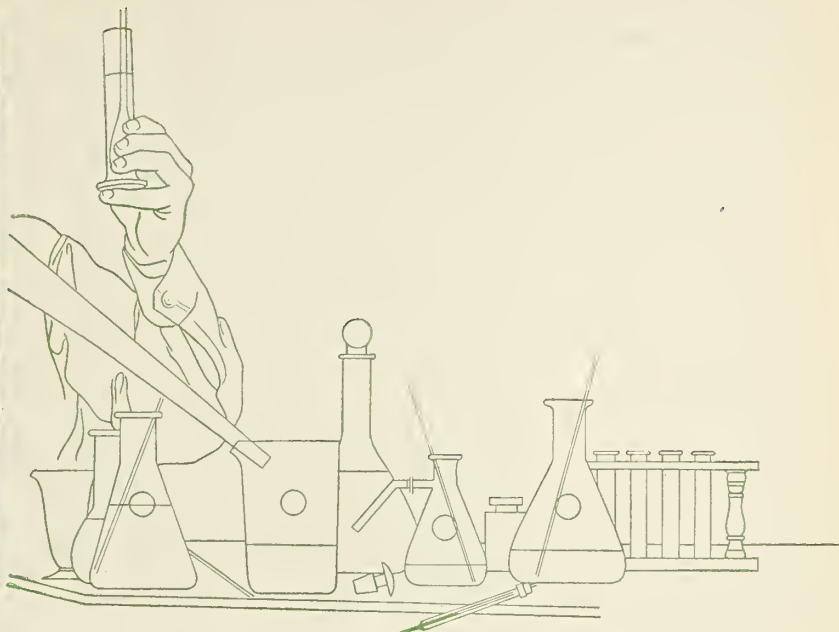
Reports of Officers

Dr. Augustus P. Hauss, president 1949. "I came here especially to hear the reports of the councilors. They bring out two things. One is that there is more alertness in the county societies than we have had in previous years. The other is that there is still much to be done. The answer is still back home in the county societies, and I believe that it is imperative that our councilors contact their county medical societies. I cannot agree with Dr. Garner when he says some of the counties are too small to get anything in the way of organized effort. Frankly, I think when the counties are small, or if there is a lack of adequate personnel, that county must be systematized more than in the case of a county where there is adequate personnel. This can be done easily and it would be very effective so far as the public is concerned.

"There is another thing that I would like to emphasize; that is, that some of the counties have very excellent programs. They are programs that are worth studying. I would like to ask that each councilor have the programs outlined by the county medical societies and sent in to our executive office so that when a county writes in and says, 'How shall we do this thing?', the executive secretary will have some references to give them. If we can exchange ideas and have a central clearing house in our headquarters I believe that we can eventually get all of the counties doing something. Whenever you can do that, then the state medical association can come out and say the Indiana State Medical Association and the medical profession are thoroughly organized to the best of their ability to serve the people of Indiana. When you do that you present the best argument you could possibly have against socialized medicine."

Dr. A. F. Weyerbacher, treasurer, reported on the bank balances on hand at this time and called special attention to the dangerously low balance in the medical defense fund. Dr. Ellison discussed this subject, saying, "This defense fund is growing smaller and smaller for two reasons. There are more suits and suits are requiring more time, and bills are getting larger. The economics of this thing are not very sane—we are collecting a fixed amount (75c from each member each year) and we are proposing to pay out an indefinite amount. It seems to me this is a thing we should begin to give some thought to. Our income is limited and our obligations are unlimited. Some ideas might be advanced. One is perhaps that we agree henceforth to pay only a certain amount toward a member's defense." Dr. C. J. Clark spoke of the advisability of the association protecting nonmember interns in malpractice cases.

Dr. Frank B. Ramsey, editor of THE JOURNAL, reported that since the first of the year advertising revenue has increased \$1,997.00. "At the present time we are planning on having our year book number in July instead of January. We have a cancer number coming out this month. We were able to collect a number of very excellent cancer articles this year. Our general



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practice number we plan for the month of August. I have asked the chairman of the General Practice Section to work with me and appoint anyone else he wishes to act as special editor of that issue."

Dr. C. H. McCaskey, chairman, Executive Committee, read as follows from the approved minutes of the March 13, 1949, meeting of the Executive Committee:

"A. M. A. national education campaign. Following a report by Dr. Nafe, chairman of the A.M.A. Campaign Coordinating Committee, and the Indiana member of the A.M.A. 'Committee of Fifty-Three,' on the Indiana phase of the campaign, including a proposed budget of almost \$30,000.00, it was voted, by motion of Drs. Hauss and Portteus, that the financial condition of the association should be called to the attention of the Council at its meeting on April 10, and that it be recommended to the Council that \$20,000.00 be appropriated from the general fund of the association to finance the Indiana campaign for the balance of 1949. This motion also included the recommendation to the Council that it propose to the House of Delegates that the state association dues be increased by from \$5.00 to \$10.00 beginning in 1950."

Dr. McCaskey reported that on recommendation of the Executive Committee, the president had appointed an Indiana A.M.A. Campaign Coordinating Committee consisting of Dr. Nafe, chairman, Dr. Portteus, Dr. Dodds and Dr. McCaskey. He then read a report from this committee which included the following recommendations and requests:

- (1) Request for \$20,000.00 budget for use during the remainder of 1949.
- (2) Employment of James A. Waggener at the same salary paid the former field secretary.
- (3) Employment of additional stenographic help as needed.
- (4) Registration in Washington of the Indiana State Medical Association as a lobbyist, and approval of the Council of the Coordinating Committee accepting funds on behalf of the state association for expenditure in the campaign.
- (5) Recommendation that business organizations and individuals be invited to give funds to the association, telling them that the association must report all contributions over \$500.00 to Congress.

Dr. McCaskey said that "the Executive Committee approved these recommendations at its meeting last night, and I bring them to you now for your consideration. After your action on them I will go further into detail." On motion of Drs. C. J. Clark and Clauser, the Council accepted the recommendations of the Executive Committee.

Dr. McCaskey then presented an agreement written by Mr. Waggener, stipulating the terms under which he would take the position of field secretary. On motion of Drs. Garber and C. J. Clark, the Council agreed to accept Mr. Waggener's proposal.

Mr. Waggener's services will be available May 15.

Dr. Hauss stressed the fact that the cost of speaking engagements should come out of the \$20,000.00 appropriation.

Unfinished Business

1. *Mutual Medical Insurance, Inc.* Dr. Kennedy, president, reported that the company is in fairly satisfactory condition, but that the coverage is not yet adequate for the needs. "There is a growth in population in the state of at least 100,000 a year, and if we are to arrive at an adequate coverage, it should soon get up to four or five times its present figure. Only 5 or 10 percent of the population of the state is covered. We should reach at least three-quarters or one

million people. So far we have tapped only that which was exceedingly profitable. We must get down to the grass roots, get it to the people out in the rural districts who really need it. The question of adequacy of our voluntary plan constantly comes up with the men in Washington. We are not enrolling fast enough."

Dr. Kennedy also spoke of sending letters to Congressmen. "Letter writing is one of the most valuable things you can do to build up constant support in Congress of the viewpoints which we have, as well as influencing opinion of the people at large."

2. *Committee on Medical and Nursing School Scholarships.* Dr. C. J. Clark, chairman, reported there had been no change in the scholarship roster of the association, which includes eleven student nurses and six medical students. A meeting of this committee will be held in time to report to the Council at its July meeting.

3. *Proposals made by Dr. C. A. Nafe, retiring president, at last Council meeting:*

(a) *Advisability of a more complete separation of the Council from the Board of Directors of Mutual Medical Insurance, Inc.*

Dr. Ellison discussed this, saying that the two boards should be separated more widely. "It is a gradual thing that can't be effected immediately but only as new members are re-elected."

Dr. Hauss warned that "Mutual Medical Insurance, Inc., must always be kept in close contact with the medical profession. I feel that the directory of Mutual Medical Insurance should always be geographically representative of all parts of the state. I think this is one thing on which we should proceed slowly. All districts should be represented by a physician."

(b) *Consideration of the proposal that the retiring president should serve for one or two years as councilor-at-large.*

Following discussion, Dr. C. J. Clark moved that an addition, which would provide that "the retiring president shall serve for a period of two years as councilor-at-large" be made to the motion passed at the October 26, 1948, Council meeting, which proposed an amendment to the By-laws "whereby each councilor district be requested to elect an alternate councilor who will act as a stand-in for the regular councilor." This motion was seconded by Dr. Howard, and passed.

(c) *Consideration of the recommendation that the House of Delegates meet twice annually instead of once as is done by the A.M.A.*

Dr. Black called attention to the fact that the House of Delegates is subject to call "when the need comes. If we have one regular session and this provision, I think that that is sufficient."

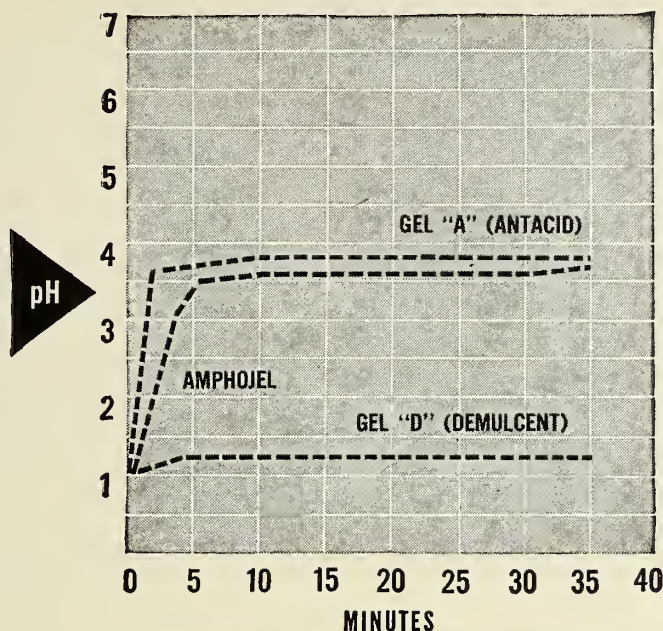
Dr. Clark said that the House of Delegates is a large and unwieldy body, and in view of the fact that if necessity arises it can always be called into session, he would not favor this recommendation.

On motion of Drs. Mitchell and Garber, the Council went on record as opposed to this recommendation.

1949 (Centennial) Annual Session at Indianapolis.

1. Dr. J. Neill Garber, chairman of the Committee on Centennial Arrangements, reported that plans for the centennial are going ahead satisfactorily. He assured the Council that his committee will stay well within the budget allowed. "We are going to do it as economically as possible and at the same time present a show that is worthy of the centennial celebration."

2. The preliminary draft of the scientific program was presented to the Council. Mr. Stump suggested that since this will be an all-Hoosier program it might



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be of interest to show the connection that each out-of-state guest speaker has with Indiana.

At the suggestion of Dr. Hauss, the House of Delegates will meet at 3:00 p.m. on Monday, September 26, and at 11:00 a.m. on Thursday, September 29.

3. "One Hundred Years of Indiana Medicine." In view of the fact that not enough orders have been received to warrant the printing of the centennial book, the executive secretary presented an alternate plan whereby the book would be published in THE JOURNAL in four installments—in June, July, August and September. Extra copies would be run and bound for those who have sent in their order in advance. This plan would effect a saving to the association of approximately \$1,000.00.

Dr. Mitchell moved that efforts be made to get a commercial firm to sponsor this publication. This motion was seconded by Dr. Kennedy, and passed.

On motion of Drs. Hauss and Garber, Dr. Mitchell was named chairman of a committee, with Drs. Reed and Elton Clarke as members, which is to attempt to secure such a sponsor. In the event that the committee is unsuccessful, the plan outlined by the executive secretary is to be followed.

Membership Problems

1. *Certification of honorary members.* On motion of Drs. C. J. Clark and Garber, the Council accepted for honorary membership in the state association three members who recently have become eligible to this classification.

2. *Organization of Crawford County Medical Society.* Dr. Garner reported that since the death of the secretary of the Crawford county society, about two years ago, it had been impossible to get the county organized because there are only three full-time doctors and one part-time doctor in the county and they are located so far apart. He will attempt, however, to get them to organize with a bordering county medical society.

Legislative Matters

Dr. J. William Wright, co-chairman of the Committee on Public Policy and Legislation, reported on the activities of his committee during the recent session of the General Assembly. He said, "Our program for next year is not to relax just because the legislature is not in session."

Dr. Wright presented the following resolution, which was adopted by the Council on motion of Drs. Mitchell and Garber:

WHEREAS, the members of the Indiana State Medical Association believe in less government control, not more; and

WHEREAS, in other countries where the government has taken over control of the medical profession, medical care has deteriorated, doctors have lost both personality and personal initiative under government rules and regimentation; and

WHEREAS, medical care plans of the government in other countries have shown extreme wastage of both medical service and tax money, crushing the people under a tax burden approaching that of war-time; and

WHEREAS, the people of the United States already face new and higher tax rates in the wake of a record peace-time budget of 42 billion dollars, on top of which a government medicine program would pile another 12 billion to the astronomical and never before equaled figure of 54 billions; and

WHEREAS, there are both nonprofit and commercial voluntary prepayment medical, surgical and hospital insurance plans now available in this country to

every working citizen and his family or dependents; and

WHEREAS, these voluntary programs are rapidly expanding to fulfill the needs of the American people for protection against the financial burden of serious illness; and

WHEREAS, the people of America are now buying this prepayment medical, surgical and hospital insurance to such an extent that 54 million individuals, approximately one-third of our total population, are now covered by voluntary insurance, removing from themselves the risk of catastrophic illness, now therefore,

BE IT RESOLVED, That the Indiana State Medical Association, through its governing body, the Council, does hereby go on record against any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control; That a copy of this resolution be forwarded to the President of the United States, to each Senator and Representative from the State of Indiana, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

INDIANA STATE MEDICAL ASSOCIATION

Chairman of the Council

Secretary

New Business

1. *A.M.A. assessment.* The chairman announced that 1901 members of the Indiana State Medical Association had paid their A.M.A. assessment.

2. *Public relations.* Dr. Dodds, chairman of the Committee on Public Relations, gave the following report:

"The Committee on Public Relations held its first meeting on January 9, 1949.

"In formulating its plans for the ensuing year, the committee has had the firm foundations laid by the work of the committee in 1948 on which to build. The central theme of the plan is that the most effective public relations must be at the local level, and that each physician must, in the final analysis, be responsible for good public relations. Physicians in Indiana have between 60,000 and 70,000 contacts daily with patients and this constitutes our most important liaison with the public.

"The newsletter entitled 'ISMA News Flashes' which was inaugurated last year, and the circulation of which was limited, is now being sent out monthly to all members of the association. An attempt is being made to include in this bulletin information which will be helpful to the physician in keeping him informed of activities at the national, state and county levels. It seems essential to the committee that physicians must be well informed to answer their patients' questions and to discuss issues intelligently.

"The response to the request of the committee that local societies take measures to insure 24-hour medical service has been very gratifying.

"Public Relations Committees are being set up in many of the county societies and our committee is of the opinion that these local committees can serve a most useful purpose. There are many groups outside of the medical profession which are vitally interested in health problems and these local committees can constitute a most important liaison with these groups. The setting up of speakers bureaus at the local level, will, in many instances, be a difficult problem but your



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The extra long action of Neo-Synephrine hydrochloride makes possible control of hay fever symptoms with infrequent dosage, thus enabling the patient to be comfortable during the day and obtain sleep at night.

Average dose: 2 or 3 drops in each nostril.

No appreciable interference with ciliary action. Virtually no side reactions.

FOR NASAL USE: $\frac{1}{4}\%$ solution (plain and aromatic), 1 oz. bottles; 1% solution, 1 oz. bottles; $\frac{1}{2}\%$ water soluble jelly, $\frac{5}{8}$ oz. tubes.

FOR OPHTHALMIC USE: $\frac{1}{8}\%$ low surface tension, aqueous solution, isotonic with tears, 15 cc. bottles.

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committee urges that, when at all possible, this be done, and that the local committees on public relations give directions to the speakers bureaus. Whenever possible, it is urged that nonmedical speakers be enlisted.

"Relations with the local press constitute a most important link in the chain and these local committees can be of great assistance in disseminating information to local newspapers. Another important function of the local committees should be the direction of the activities of the Woman's Auxiliary. The auxiliaries can integrate their activities into many community activities which will be of inestimable value from the public relations standpoint. In short, the local committees should concern themselves with every phase of medical activity which has any bearing on public relations.

"Your committee has recommended to the Executive Committee that a Speakers' Bureau be set up at a state level to furnish speakers for large groups or at the request of county medical societies.

"Many helpful suggestions have been received from members of the association, and it is urged that members continue to send in helpful suggestions so that your committee may be assisted in its work."

3. *Veterans' affairs.* Dr. Garner, chairman of the Committee on Veterans' Affairs and Rehabilitation, reported as follows: "We have in Indiana 170 doctors who have graduated either with help or by being deferred so that they could complete their medical education. We have made an effort to get our quota for the armed forces, which would be approximately 40. Because these young doctors are not volunteering we sent out a letter to each graduate under 26 years of age, encouraging them to enlist, saying it is their duty and responsibility to fall in line. We have had very poor results. Out of the 170, up to our last information only eleven had been encouraged to join up. National headquarters is requesting 1,600 by July 1 and 2,200 by the end of the year. We have 8,000 graduates either deferred or part paid from which to get 2,200. If other states are getting the same results as we in Indiana are I believe this present Congress will pass draft legislation for doctors."

Mr. Stump suggested that something be said and done about this matter at this time to avoid bad publicity for the medical profession. "It would be wise to modify this thing enough that we don't have a story out that the medical profession fell down. I think we should go on record as saying, with all fairness to all concerned, that these individuals whose education was paid for in toto or in part and who have had no opportunity to repay their country, should serve equally in the draft."

Dr. Garner said he would be in favor of suggesting to the A.M.A. that it reverse its stand and request Congress to give the A.M.A. a draft plan on which to work. This should be done soon enough that it would appear that the A.M.A. originated the movement.

On motion of Drs. Hauss and Black, Drs. Ramsey, Garner and C. J. Clark were named members of a committee to draw up a resolution embodying the thoughts expressed in this discussion. This committee offered the following resolution, which was adopted by the Council:

"To the American Medical Association:

"WHEREAS: Doctors have not volunteered in sufficient numbers to meet the armed services' requirements for medical men, and

"WHEREAS: Many doctors have been educated at total or partial government expense, and

"WHEREAS: Many doctors were deferred from service in order to complete their educational requirements, and

"WHEREAS: Unfavorable publicity toward the medical profession generally would be occasioned by a draft sought from other sources,

"Therefore Be It Resolved, That the American Medical Association be requested to reconsider its previous stand, and to take the leadership in guiding draft legislation for physicians.

"Council of the Indiana
State Medical Association."

On motion of Drs. May and Howard, the suggestion made by Dr. Hauss that a copy of this resolution be sent to each of these young Indiana graduates who are expected to join the armed services was adopted.

4. *1949 budget.* The executive secretary read a memorandum prepared by Dr. Nafe, chairman of the Budget Committee, in which Dr. Nafe presented and explained budget allowances for 1949. In part the report read: "You will note that the anticipated revenue for the association for 1949 is \$67,702.50, and the total appropriations made by the Budget Committee amount to \$82,118.50, which leaves an anticipated deficit of \$14,416.00. . . . It is probable that some of the committees will not spend all of their appropriation and that there will be methods of economizing, but this is the picture as it stands. I am calling all of this to your attention in order that you may take whatever action is necessary, at the next Council meeting, to devise ways and means of meeting these expenses."

The Council took no action on this matter.

5. *Nominations for Editorial Board.* Dr. Wemple Dodds, Crawfordsville (roentgenology) and Dr. Stephen L. Johnson, Evansville (internal medicine) were nominated at the midwinter meeting of the Council on January 16, 1949. No further nominations were made at this time.

6. *Summer meeting of the Council.* It was taken by consent that the next meeting of the Council shall be held on Sunday, July 31, 1949.

There being no further business, the meeting was adjourned.

EXECUTIVE COMMITTEE

April 9, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; Walter L. Portteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D. A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guest: Cleon A. Nafe, M.D., chairman, Indiana A.M.A. Campaign Coordinating Committee.

Statements of receipts and expenditures for March for the association and THE JOURNAL were approved.

Membership Report

Number of members April 6, 1949	3,488*
Number of members April 6, 1948	3,416
Gain over last year	72
Number of members Dec. 31, 1948	3,685

* Includes 26 in military service (gratis)
166 honorary members

Treasurer's Office

On motion of Drs. Portteus and Black, the committee voted to increase the Petty Cash Fund from \$200.00 to \$500.00.

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*Goat's milk and processed cows' milk have unmodified casein factors.

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1948 Annual Session, Indianapolis, October 26, 27 and 28, 1948

The following report from the 1948 Committee on Instructional Courses was presented:

Total receipts from Instructional Course fees	\$451.00
Committee expense	325.53

Balance remitted to state medical association	\$125.47
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1949 Annual Session, Indianapolis, September 26-29, 1949

Publicity. The executive secretary was directed to contact the advertising managers of *The Indianapolis Star* and *The Indianapolis Times* to see if they would be interested in running a special section devoted to the one-hundredth anniversary meeting of the association in their editions on Sunday, September 25, 1949.

Action on the request of the chairman of the Committee on Rural Medical Care that he be allowed twenty minutes during the annual session to report on the activities of his committee was deferred until after the meeting of the Committee on Civic Relationship and Community Health Agencies which is to be held on April 24.

Legislative Matters National

A.M.A. national education campaign.

a. Report of the chairman of the Indiana A.M.A. Campaign Coordinating Committee was accepted, on motion of Drs. Hauss and Portteus. This committee was empowered to employ speakers that it deems necessary, on motion of Drs. Portteus and Hauss.

On motion of Drs. Ellison and Black, it was voted to recommend to the Council the employment of Mr. James A. Waggener as field secretary.

On motion of Drs. Ellison and Portteus, it was voted to allow 7c a mile for automobile travel to all lay employees of the association.

b. Letter from the A.M.A. Bureau of Legal Medicine and Legislation on question of lobby registration was referred to the association's attorney.

c. On motion of Drs. Hauss and Portteus, it was voted to accept \$2,600.00 from the Indianapolis Medical Society for expenses of the centennial convention in September.

It was taken by consent that the executive secretary stop at Washington enroute to Atlantic City in June to contact the Indiana delegation in Congress regarding the compulsory sickness insurance legislation.

Letter from the National Congress of Parents and Teachers, asking the association's support of certain legislation, was referred to the Committee on Public Policy and Legislation on motion of Drs. Hauss and Ellison.

Organization Matters

Suite for A.M.A. meeting at Atlantic City. The chairman of the Executive Committee offered to investigate the possibility of procuring a suite at Hotel Traymore at Atlantic City, for use as Indiana headquarters for the 1949 A.M.A. convention, after a letter was read from Dr. George Lull, saying that suites are available only to delegates.

The question of whether local insurance agents may participate in the Blue Shield-Blue Cross plans was deferred until the next meeting.

The offer of the Provident Life and Accident Insurance Company to write a group policy on members of the state association was rejected by consent.

National Health Assembly. Letter from the Lake County Medical Society, stating its objection to three lay health organizations contributing to the National Health Assembly, was read.

Red Cross Blood Program. Letter from the secretary and general manager of the A.M.A., explaining that a survey is being made of blood banks, was read.

The committee decided by consent to adopt the policy of the Indiana State Chamber of Commerce in not protesting against excise taxes, as had been requested of the association by Western Union Telegraph Company.

Suggested letter from Mutual Medical Insurance, Inc., to be sent to Indiana publishers over the signature of the executive secretary of the Indiana State Medical Association, asking for advertising rates, was disapproved, on motion of Drs. Portteus and Black.

Dr. D. Lee Andrews' case. Decision of the Indiana Supreme Court in the case of Dr. D. Lee Andrews, which ruled that county medical society membership is not a valid requirement for staff membership in certain county-owned hospitals, was explained by Mr. Stump.

School and Community Health Education Workshop. On motion of Drs. Portteus and Black, invitation to the state medical association to participate in the School and Community Health Education Workshop at Bloomington August 12-26, was accepted.

Indiana Mental Hygiene Society. On motion of Drs. Ellison and Hauss, approval of copy of a letter and folder submitted by the Indiana Mental Hygiene Society was postponed until the next meeting.

World Medical Association. Letter from the World Medical Association, requesting a contribution and a place for a speaker on the annual convention program and the distribution of literature, was read. The request for funds and time for a speaker was rejected, but it was agreed that literature from this organization should be distributed at the annual session of the state medical association.

Unemployment tax. The executive secretary reported that the Indiana Employment Security Division, in a letter dated March 8, 1949, has ruled that the state medical association will be liable to unemployment tax when the number of persons on the payroll reaches eight or more, including part-time employees.

Woman's Auxiliary

On motion of Drs. Ellison and Black, the appointment of a committee to develop a program for the Woman's Auxiliary in 1949-1950 was approved.

The Journal

Report on advertising:

Increase to April 9, 1949	\$ 461.80
Decrease	102.00

Total increase for month	\$ 359.80
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Total increase for year	\$1,997.50
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There being no further business, the committee adjourned to meet again at 10:00 a.m., Sunday, May 22, 1949, at the Columbia Club.

COMMITTEE ON PUBLICITY

March 11, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and Larry Richardson, field secretary.

The executive secretary read a news release from the Illinois State Medical Society reporting that the \$25.00 assessment was being willingly paid by members with the prediction that final results would show at least 90 percent of the doctors had contributed. He also reported that more than one-third of the total Indiana membership has made its \$25.00 contribution.

It was reported to the committee that copies of the book, "The Case Against Socialized Medicine," had been

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**May we send you copies of these published studies:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

distributed to college libraries and county medical society secretaries.

The following "Hints on Health" news releases were approved:

Week of April 11, 1949—"Poison Accidents."

Week of April 18, 1949—"Cancer of the Mouth."

Week of April 25, 1949—"Vital Food."

The committee approved the printing of 5,000 copies of a talk against socialized medicine by Dr. Herman B. Wells, president of Indiana University. This talk will be distributed in folder form, and the committee instructed that Dr. Wells be permitted to correct the copy before actual printing.

The following speaking engagements received the approval of the committee:

March 14, 1949—University Club, Anderson. "Socialized Medicine," field secretary.

March 15, 1949—Delaware-Blackford County Medical Society, Muncie. "Socialized Medicine," field secretary.

March 17, 1949—Henry County Medical Society, New Castle. "Socialized Medicine," field secretary.

March 22, 1949—Indiana University Nurses Alumnae Association, Indianapolis. "Socialized Medicine," executive secretary.

March 24, 1949—Business and Professional Woman's Club, Indianapolis. "Socialized Medicine," field secretary.

March 25, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and Larry Richardson, field secretary.

The following "Hints on Health" news releases were discussed, corrected, and approved:

Week of May 2, 1949—"Housecleaning Made Easy."

Week of May 9, 1949—"Blessing in Disguise."

Week of May 16, 1949—"Beware of Bursitis."

Week of May 23, 1949—"The Baldness Racket."

The Indiana Social Hygiene Association packet of booklets was read and approved.

Proof of the pamphlet containing a talk by Dr. Herman B. Wells against socialized medicine was reviewed by the committee. Five thousand copies of this pamphlet are to be printed to be included with other printed material on socialized medicine which will be sent to each member of the state medical association. Each physician will have the opportunity to order as many copies of each of the pamphlets as he desires for distribution to his patients, civic clubs and various community groups.

A four and one-half minute song recording for a sample of the type of program to be offered county medical societies for their sponsorship on local stations was played for the committee and received its tentative approval.

The following speaking engagements received the approval of the committee:

March 17, 1949—Parent-Teacher Association, School No. 1, Indianapolis. "Socialized Medicine," association attorney.

March 22, 1949—Rotary Club, Vincennes. "Socialized Medicine," association attorney.

March 29, 1949—Woman's Auxiliary to Indianapolis Medical Society, Indianapolis. "Socialized Medicine," executive secretary.

March 29, 1949—Clark County Medical Society, Jeffersonville. "Socialized Medicine," field secretary.

April 5, 1949—Cooperative Club, Indianapolis. "Socialized Medicine," field secretary.

April 12, 1949—Kiwanis Club, Winchester. "Socialized Medicine," field secretary.

COMMITTEE ON RURAL MEDICINE

March 6, 1949

Meetings were called by Frank Sink, M.D., of Remington, chairman of Committee on Rural Medical Care, with the following members present: Margaret Bassett, M.D., Thornton; Dan L. Urschel, M.D., Mentone; L. W. Vore, M.D., Plymouth; H. N. Smith, M.D., Brookville; George S. Row, M.D., Osgood; William E. Schoolfield, M.D., Orleans; Louis E. Howe, M.D., Lakeville; F. S. Crockett, M.D., Lafayette, chairman of the Committee on Rural Health of the American Medical Association; Mr. Ray E. Smith, Indianapolis, executive secretary, and Mr. Larry Richardson, Indianapolis, field secretary and secretary to the Committee on Rural Health.

Doctor Crockett opened the meeting with some background on the rural health movement, saying it had been formally instigated in 1945 when representatives of the Farm Bureau had come to the American Medical Association asking for assistance in establishing a rural health program. Out of this was born the National Rural Health Conference series, which has met regularly since 1946. That year the conference discussed the general picture of rural medical care, followed successively by an examination of special problems such as distribution of doctors, nurses and hospitals in the 1947 meeting, the rural youth health problem in 1948, and the overall picture of rural hygiene during the sessions this year.

Doctor Crockett conceived the problem of the Indiana Rural Health Committee to be:

1. Transfer of the national objectives to the state level.

2. Getting full cooperation from nonmedical community groups. There was an effort made to effect just such a transfer from national to local levels after the 1946 meeting, when Farm Bureau agents were asked to take initiative in establishing Community Health Councils, but after such community groups had been formed, they failed to function because no program had been worked out for them to follow; at least that was the experience in Indiana.

Doctor Crockett then went on to explain that the community health council idea had undergone a rebirth in Indiana due to the good services of Purdue University's Rural Extension Department. The Indiana Board of Health has loaned Mr. Malcolm Mason, a native Hoosier and a University of Michigan graduate with a Master's Degree in Public Health, to Purdue for the express purpose of establishing health councils around the state, or revitalizing those still extant.

A county health council, by Doctor Crockett's own definition, is: "An organization representing all community groups, for the purpose of community improvement, aimed specifically toward better health for the individual and the general public."

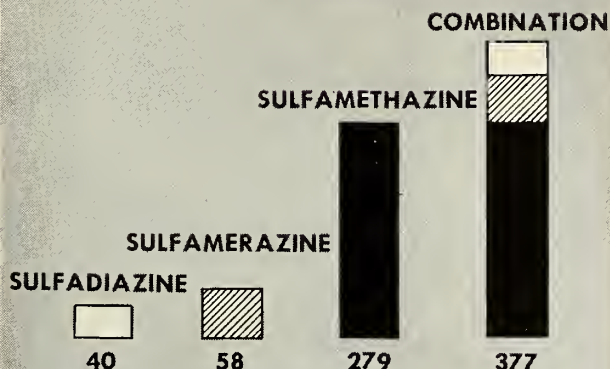
As the Rural Health Committee meeting progressed, the discussion became more widespread, and it was suggested that one of the first problems of a newly created county health council should be to survey the health needs of its community. From that study should come clear recognition of one big problem which the health council could take immediate steps to remedy. It was the committee's feeling that Hoosier doctors should be well represented on these health councils and should be the authority and guide in all medical thinking done by the councils.

Doctor Sink suggested there was a deep need for educating Indiana doctors to the necessity for working with lay groups interested in health improvement on the community level. He added that being in personal touch with lay groups would give the medical profession valuable clues as to the thinking of the public toward

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¹ Whitby, L.: Practitioner 155: 264 (1945).



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medicine, and help us orient ourselves in the fight against socialized medicine.

Doctor Crockett then proposed that the Rural Health Committee ask the Executive Committee of the state association to request each county medical society to appoint a Committee on Rural Health.

However, immediate action on the question was postponed by committee action after general discussion indicated all members wanted to know more about the 60 county health councils now functioning. Since the county health councils seem to be the logical vehicle for the medical profession in future attempts to improve rural health, the committee decided to invite Mr. Malcolm Mason of Purdue University, the previously mentioned specialist in rural health matters, to the next meeting; also to be invited are Dr. Leroy Burney and Dr. Daniel C. Barrett of the Public Health Service. These men are expected to give the Rural Health Committee a complete picture on existing organizations and activities in the rural health field.

The committee voted unanimously to submit a questionnaire concerning county health councils to the secretaries of their own and adjacent county societies, the results to be discussed at the next meeting. The next meeting of the Rural Health Committee was set for March 20, 1949, at the Columbia Club, in Indianapolis

March 20, 1949.

Present: a. Committee—Frank Sink, M.D., George Row, M.D., Louis Howe, M.D., L. W. Vore, M.D., Dan Urschel, M.D., H. N. Smith, M.D., W. E. Schoolfield, M.D., Margaret Bassett, M.D.

b. Ex-Officio—Franklin S. Crockett, M.D.

c. Guests—A. P. Hauss, M. D., President, Indiana State Medical Association; Dan C. Barrett, M.D., Director Local Health Administration, and Leroy Burney, M.D., Director, State Board of Health; Mr. Malcolm Mason, Rural Extension Activities, Purdue University, and Mr. Harold Smith, Ph.D., Dept. of Sociology and Economics, Purdue University.

Meeting called to order at 10:45 A.M., Frank Sink, M.D., chairman, presiding. Minutes of the previous meeting were read and approved. The county health council questionnaires were called in and examined. Returns are incomplete; information available indicates that five county health councils exist but are dormant, six counties have no council, one county is organizing such a group, and eight counties did not reply to the questionnaire.

Mr. Malcolm Mason of Purdue, a specialist in county health council activities, declared there are between twenty-two and twenty-four active health councils in Indiana today. In discussing replies to a recent questionnaire which he personally had sent out, Mr. Mason said all but two replies indicated they wanted medical profession leadership in the county health councils. He added that many replies indicated that the medical profession in certain localities had blocked the setting up of health councils. Where doctors had thrown full cooperation behind the councils, however, they made excellent progress.

Mr. Mason was of the opinion that the county health councils need explicit information about WHY they are organized, and then they must be given specific tasks to perform until they find problems of their own to attack.

In subsequent discussion, Mr. Mason brought out that county health councils were always composed of both rural and urban citizens. He designated some of their activities as: setting up physical examinations in schools, T-B tests, health clubs, nutrition survey, teeth checkup, getting a needed county nurse, setting up local hospitals, health surveys in the community, Bang's disease tests, et cetera.

Mr. Malcolm Mason offered the information that his surveys have never indicated a serious shortage of doctors in Indiana, despite occasional complaints that certain small communities would like to have their own local doctor.

Dr. Louis Howe then showed two maps which he had created to visualize the unequal distribution of hospitals and doctors in the state. Dr. Crockett pointed out that the job of the medical profession was to aid and abet the county health councils, not take them over. Dr. Row maintained the county health responsibility now rests on the county health nurse where one is available; he pointed out that this nurse usually had no organized backing in her efforts.

General discussion brought out that county health councils usually lacked strong leadership, and certainly one of the first steps in reorganizing such groups would be to appoint a recognized and responsible leader.

Dr. Barrett suggested that Hoosier doctors need to be informed on what a county health council should do, then they, the doctors, should assume the leadership and general guidance. Dr. Barrett also held the opinion that every county needs a full time health officer. The busy practitioner cannot carry the load of the added responsibility of policing and creating the community's health.

It was his observation that the people of a community want good health, and they don't mind an increase in tax rate to get it, when that extra tax money can buy the service of a full time public health officer. He suggested that community doctors might well instigate a referendum at coming elections in order that the people might vote such a department into existence if they really want it. Dr. Barrett was further of the opinion that voluntary health agencies had come into existence because the medical profession had failed to meet community needs. A full time public health department in every community could gradually take over and absorb those duties the voluntary health agencies had taken unto themselves.

Earlier in the meeting, Dr. Crockett had suggested that the chairmen of the active county health councils and the secretaries of the immediately associated medical societies be brought in for a special meeting to evolve an overall program for Indiana county health councils. In subsequent discussion it was agreed that such a group might be unwieldy. On a motion by Dr. Louis Howe and seconded by Dr. Vore, it was agreed that a smaller group should be appointed to meet with Mr. Malcolm Mason of the Purdue Extension Division in order to create an agenda for a future meeting with extant county health council chairmen, as well as set an upper limit on the number invited to such a study meeting. Dr. Sink then appointed himself, Dr. Howe, and Dr. Bassett to that subcommittee, with Dr. Crockett as adviser, plus Malcolm Mason and Dr. Smith, Purdue Sociologist. The committee will meet on March 31, at 7 P.M., in Dr. Sink's home in Remington. Dr. Hauss, association president and a guest at the meeting, was called upon to speak and made commendatory remarks on the committee's progress and the contribution of the ex-officio adviser, Dr. Crockett. The meeting adjourned at 2:45 P.M., the next full committee meeting to be called when the subcommittee has completed its study.

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COUNCILOR DISTRICT MEETING

TWELFTH DISTRICT

Dr. M. B. Catlett of Fort Wayne was elected councilor from the Twelfth District at a meeting of the Twelfth District Medical Society in Fort Wayne on April 5. He will succeed Dr. Paul A. Garber of South Bend on January 1, 1950. Doctor Garber did not seek re-election.

Other officers elected were Dr. Karl M. Beierlein, president; Dr. Arthur R. Savage, vice-president; and Dr. William J. Gerding, secretary-treasurer. All are from Fort Wayne.

Three excellent scientific lectures were presented at the meeting, as follows:

"Obstetrical Helps," by Dr. C. O. McCormick, clinical professor of obstetrics, Indiana University School of Medicine, Indianapolis.

"Management of Acute Abdominal Emergencies," by Dr. Manuel E. Lichtenstein, associate professor of surgery, Northwestern University Medical School, Chicago.

"Use and Misuse of Sex Hormones," by Dr. Willard O. Thompson, clinical professor of medicine, University of Illinois College of Medicine, Chicago.

Dr. Arthur N. Ferguson invited physicians in the district to attend the scientific meetings of the Allen County Medical Society. A report on activities of the Indiana State Medical Association was made by Ray E. Smith, executive secretary.

Dr. Benjamin F. Pence of Columbia City, president of the district society in 1948-49, presided.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

BARTHOLOMEW-BROWN COUNTY MEDICAL SOCIETY

President, George W. Macey, Columbus,
Vice-President, Robert B. Hart, Columbus,
Secretary-Treasurer, David L. Adler, Columbus.

DEARBORN-OHIO COUNTY MEDICAL SOCIETY

President, C. W. Olcott, Aurora,
Vice-President, F. A. Streck, Lawrenceburg,
Secretary-Treasurer, C. N. Manley, Rising Sun.

LAWRENCE COUNTY MEDICAL SOCIETY

President, K. T. Edmonds, Bedford,
Vice-President, William Strickland, Mitchell,
Secretary-Treasurer, John P. Scherschel, Bedford.

MIAMI COUNTY MEDICAL SOCIETY

President, E. E. Shrock, Amboy,
Vice-President, J. E. Yarling, Peru,
Secretary-Treasurer, C. R. Herd, Peru.

PARKE-VERMILLION COUNTY MEDICAL SOCIETY

President, S. C. Darroch, Cayuga,
Secretary, E. M. Merrell, Rockville.

SULLIVAN COUNTY MEDICAL SOCIETY

President, J. E. Dukes, Dugger,
Vice-President, J. H. Crowder, Sullivan,
Secretary, J. S. Brown, Carlisle.

VIGO COUNTY MEDICAL SOCIETY

President, I. B. Loving, New Goshen,
Vice-President, H. T. Goodman, Terre Haute,
Secretary-Treasurer, A. M. Mitchell, Terre Haute.

WHITE COUNTY MEDICAL SOCIETY

President, H. B. Gable, Monticello,
Secretary-Treasurer, Henry W. Griest, Monticello.

Dearborn-Ohio County Medical Society members met at the Schenley Cafeteria, in Lawrenceburg, on March 17. The twelve members present heard Dr. Robert Anzinger, of Cincinnati, speak on "Management of Diabetes Mellitus."

DeKalb County Medical Society held a meeting at the Auburn Hotel, in Auburn, on March 23. This was a business meeting, and ten members were present.

Elkhart County Medical Society members met at the Hotel Elkhart, in Elkhart, on March 3. Dr. L. E. Burney, of Indianapolis, and representatives of Blue Cross-Blue Shield were the guest speakers.

Greene County Medical Society members held a business meeting at the Freeman Greene County Hospital, in Linton, on March 17. Sixteen members were present.

Howard County Medical Society members met in Kokomo, on March 4, when Dr. L. J. Clark, of Indianapolis, was the guest speaker. Twenty-four members were in attendance, to hear Dr. Clark's discussion of "Congenital Malformations."

Knox County Medical Society members held a meeting in the Grand Hotel, in Vincennes, on February 15. Mr. Larry Richardson, field secretary of the state association, spoke on "Socialized Medicine." Eighteen members were present.

Another meeting was held on March 15, when Dr. William Montgomery, of Indianapolis, spoke on "Recent Advances in Carcinoma of the Pancreas." Twenty-four members attended this meeting.

Madison County Medical Society members held a meeting on March 21 at the Anderson Country Club, in Anderson. Dr. Harry E. Northam, of Chicago, was the guest speaker. His subject was "Principles and Objectives of the American Association of Physicians and Surgeons in Regard to Compulsory Health Insurance."

Montgomery County Medical Society held a meeting at the Culver Hospital in Crawfordsville on March 17. The guest speakers were Dr. Earl Mericle, of Indianapolis, whose subject was "Psychiatric Treatment," and Dr. C. B. Fausset, of Indianapolis, who spoke on "Newer Aspects of Neural Surgery." Twenty-nine members were present.

Putnam County Medical Society members held a meeting at the College Inn, in Greencastle, on March 11. Mr. Larry Richardson, field secretary of the state association, spoke on the Federal Health Insurance Bill. Eighteen members and four guests were in attendance.

Tippecanoe County Medical Society members met at Lincoln Lodge, in LaFayette, on March 8. Dr. Philip Thorek, of Chicago, spoke on "Carcinoma of the Esophagus," and Dr. Max Thorek, also of Chicago, spoke on "Hirschsprung's Disease." Seventy members and guests were present.

Wells County Medical Society members held a combined meeting with the Woman's Auxiliary to the Wells County Medical Society, on March 21, at the Bluffton Country Club, in Bluffton, in honor of Dr. Claude S. Black, of Warren, president-elect of the state association, and of Mrs. W. R. Morrison, of Kokomo, president of the state auxiliary. The guest speaker was Mr. Floyd Mattice, Indianapolis attorney. Seventy members and guests were present at this meeting.



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GYNECOLOGY—Intensive Course, Two Weeks, Starting June 20, September 26. Vaginal Approach to Pelvic Surgery, One Week, Starting May 16, June 13, September 19.

OBSTETRICS—Intensive Course, Two Weeks, Starting May 16, September 12.

MEDICINE—Intensive General Course, Two Weeks, Starting June 13, October 3. Electrocardiography & Heart Disease, Two Weeks, Starting July 18. Gastroenterology, Two Weeks, Starting June 27. Personal Course in Gastroscopy, Two Weeks, Starting May 16, June 13.

PEDIATRICS—Diagnosis & Treatment of Congenital Malformations of Heart, Two Weeks, Starting June 13. Personal Course in Cerebral Palsy, Two Weeks, Starting August 1.

DERMATOLOGY—Formal Course, Two Weeks, Starting June 13. Informal Clinical Course Every Two Weeks.

CYSTOSCOPY—Ten Day Practical Course Every Two Weeks.

UROLOGY—Intensive Course, Two Weeks, Starting September 26.

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PROGRAM

Twenty-Sixth Annual Meeting
Atlantic City, New Jersey, June 6-10, 1949
Hotel Haddon Hall

Mrs. JAMES H. MASON, CHAIRMAN,
Committee on Arrangements

A cordial invitation is extended to all members of the Woman's Auxiliary to the American Medical Association, their guests, and guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at Hotel Haddon Hall. Tickets will be available at the registration desk. Please register early and obtain your badge and program.

PRECONVENTION MEETINGS

Sunday, June 5

- 12:00 Noon The members of the Hospitality Committee will welcome members and guests of the Woman's Auxiliary.
4:00 P.M. Committee Meetings
1:00 P.M. Nominating Committee—Rowsley Room (first floor).
8:00 P.M. Finance Committee—Bakewell Room (first floor).

Monday, June 6

- 9:30 A.M. Board of Directors—Room 124 (first floor).
10:00 A.M. Round Table Discussions (Open to state officers and chairmen).
12:00 Noon Luncheon and meeting of the Board of Directors—Bakewell Room (first floor).
3:00 P.M. Revisions Committee—Rowsley Room (first floor).
4:00 P.M. Tea honoring Luther H. Kice, president, and Mrs. David B. Allman, president-elect, for the members of the National Board of Directors and state presidents and presidents-elect and guests, Benjamin West Room.
to
6:00 P.M. Tickets \$1.50. All doctors' wives are cordially invited.
Hostesses: The Woman's Auxiliary to the Medical Society of New Jersey.
8:30 P.M. Fashion Show—Ballroom, Convention Hall.

PROGRAM

Tuesday, June 7

- 9:00 A.M. Formal opening of the Twenty-sixth Annual Meeting of the Woman's Auxiliary to the American Medical Association, Vernon Room, (Lounge Fl.).
Presiding—Mrs. Luther H. Kice, *President*
Invocation—Reverend Harvey Bennett, *Pastor*, First Presbyterian Church
Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association
Mrs. Eustace A. Allen
Greetings—Honorable Joseph Altman, Mayor of Atlantic City
Browne Holoman, M.D., *President*, Atlantic County Medical Society
Address of Welcome
Mrs. Robert B. Walker, *President*, Woman's Auxiliary to the Medical Society of New Jersey
Response
Mrs. John S. Bouslog, *Past president*, Woman's Auxiliary to the Colorado State Medical Society
Presentation of Convention Chairman
Mrs. James H. Mason
Introductions—Mrs. Luther H. Kice
Presentation of President-Elect
Mrs. David B. Allman
Roll Call—Mrs. George Turner, *Constitutional Secretary*
Minutes of the Twenty-Fifth Annual Meeting—Mrs. George Turner
Convention Rules of Order
Mrs. J. K. Avent
Credentials and Registration
Mrs. Mathew Molitch
Address of the President
Mrs. Luther H. Kice

REPORTS OF OFFICERS

- 12:30 P.M. Luncheon in honor of the Past Presidents of the Woman's Auxiliary to the American Medical Association, Rutland Room (first floor).
Tickets \$4.00.
2:00 P.M. Report of the Board of Directors.
Reports of Chairmen of Standing Committees.
Report of Special Committee.
Report of the Historian.
Report of the Central Office and Bulletin Circulation.
Report of the Nominating Committee (first reading).
Election of the 1950 Nominating Committee.
4:00 P.M. Round Table Discussion (continued).
8:00 P.M. Opening meeting of the American Medical Association—Ballroom, Convention Hall. Members of the Woman's Auxiliary and guests are welcome.

Wednesday, June 8

- 9:00 A.M. General Session of the Woman's Auxiliary to the American Medical Association, Vernon Room, Lounge Floor.
Minutes.
Announcements.
Credentials and Registration.
In Memoriam.
Resolutions.
Reports of State Presidents.
12:15 P.M. Annual Luncheon in honor of Mrs. Luther H. Kice, President, and Mrs. David B. Allman, President-Elect, Rutland Room (first floor).
Tickets \$4.00.
Guests of Honor: Dr. R. L. Sensenich, president, American Medical Association; Dr. Ernest E. Irons, president-elect; Dr. Elmer L. Henderson, chairman, Board of Trustees; Dr. J. J. Moore, treasurer; Dr. George F. Lull, secretary and general manager; Dr. Morris Fishbein, editor, *Journal and Hygeia*; and the members of the Advisory Council to the Woman's Auxiliary.
1:30 P.M. Joint meeting of the Advisory Council of the American Medical Association and the Board of Directors of the Woman's Auxiliary, Garden Room (Lounge Floor).
3:00 P.M. Unfinished Business.
New Business.
Report of the Nominating Committee.
Election of Officers.
Installation of Officers and Presentation of President's Pin.
Inaugural Address.
Convention Courtesy Resolutions.
Minutes.
Adjournment.

Thursday, June 9

- 9:30 A.M. Meeting of the Board of Directors, Solarium, (Lounge Floor).
10:30 A.M. Conference of State Presidents, Presidents-Elect, National Officers and Chairmen of Standing Committees, Solarium, (Lounge Floor).
6:30 P.M. Annual Dinner of the Woman's Auxiliary for members, husbands and guests—Vernon Room (Lounge Floor).
Formal—Tickets \$6.00.
9:00 P.M. Reception and Ball in honor of the President of the American Medical Association, American Room, Hotel Traymore.

Friday, June 10

Exhibits at Convention Hall.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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VOLUME 42

JUNE, 1949

NUMBER 6

INTUSSUSCEPTION IN ADULTS

A REPORT OF FOUR CASES

WILL C. MOORE, M.D.

HECTOR C. MARSH, M.D.

CLYDE E. RUSH, M.D.

MUNCIE

INTUSSUSCEPTION in adults is rare, and a large series of cases is unusual. There were five cases of intussusception in adults at Peter Bent Brigham Hospital in Boston during the period from 1913 to 1940. Kahle¹ reports twenty-eight cases, sixteen years of age and over, from 1904 to 1938 at Charity Hospital in New Orleans. Eliot and Corscaden² in 1911 had collected a total of 300 cases of intussusception in adults. In 1941 Nichols³ reported more than 200 cases in the world's literature between the years 1936 and 1939. Other writers have seen this condition rarely. We have seen four cases of intussusception in adults within five years.

ETIOLOGY

Of all intussusception, 75 percent is found in infants under two years of age and the greatest portion of the remaining 25 percent occurs before puberty. The cause of intussusception in infants is rarely found, but in adults the exciting lesion as a rule can be discovered at or before operation. This lesion is often a tumor. It is felt that an intussusception results when there is a proximal spastic zone of bowel over which the longitudinal muscle fibers draw up a distal portion of gut. This may or may not explain the role of benign polypoid tumors, carcinomata, foreign bodies and Meckel's diverticula in intussusception. Croce and Wiper⁴ report a case of cecocolic intussusception in which an abnormally wide mesentery of the terminal

ileum, cecum and ascending colon was the predisposing factor. Shearer and Creer⁵ confirm this observation. Botsford and Newton,⁶ quoting Wordill, state that "The tumor acts as a foreign body within the lumen of the gut and produces spasmodic contractions of the gut around it, and inhibition of the bowel just distal to it. Thus the bowel is prepared to invaginate and the contracted portion with the tumor may enter the dilated segment." Saint⁷ is of the opinion that intussusceptions are never caused by passive drag of the tumor on the bowel wall, but by an active effort of the bowel musculature to extrude what is really a foreign body. The most common variety is that in which a proximal intussusceptum enters a distal intussusciens.

Intestinal tumors, intestinal ulcers due to bacterial diseases of the gut, and Meckel's diverticula comprise the most frequent causes of intussusception in adults. Tumors caused all intussusceptions in our group of cases. Of these, two were lipomata and two were carcinomata.

Lipomata constitute roughly 3 percent of all benign tumors of the bowel and are believed to arise from fat cells of the bowel wall. Fobes⁸ discusses eighty cases of intussusception in adults due to lipomata of the gut. He also states that he found only six cases of cecocolic intussusception produced by lipomata of the cecum. The lipomata in both of our cases originated in the cecum. Staemmler and Comfort discovered lipomata of

the intestine in 0.05 percent and 0.06 percent, respectively, of over 20,000 autopsies. During life, this tumor may cause no symptoms. Therefore, lipomata probably occur more frequently than is widely believed. These tumors are almost never congenital, usually occur as single polypoid masses, and do not undergo malignant change. Symptoms arise when the tumor becomes large enough to obstruct the bowel, and when obstruction develops, intussusception is found in from 40 to 45 percent of cases.

Helwig⁹ and others have noted the incidence of adenomata in the large bowel. In 1,460 consecutive autopsies, Helwig found adenomata in 139, or 9.5 percent, being increasingly common after the fourth decade. This author also presents evidence to support the thesis that adenomata of the large bowel do undergo malignant transition and, in fact, that the majority of carcinomata of the large intestine have their origin in adenomata. Bockus¹⁰ states that 40 percent of patients with carcinoma of the large bowel suffer obstructive symptoms such as distention, colic and constipation. Of these patients with partial or complete obstruction, 85 to 90 percent have lesions in the left colon. If obstruction of the colon is diagnosed but its site in the large bowel is not localized, the chances (excluding hernia and intussusception) are nine to one that it is due to malignancy and six to one that it is on the left side of the colon. Three-fourths of left-sided tumors produce partial or complete obstruction. About one-half of the tumors of the rectum produce obstruction, but this is usually of a low grade character. Malignant tumors of the splenic flexure cause obstruction twice as often as lesions of the other parts of the large bowel, probably because the splenic flexure is normally of smaller diameter than any other part of the colon.

Intussusception is often found with acute obstructions due to carcinomata. Eliot and Corscaden² noted that malignant tumors were found in 40 percent of their cases in which the intussusception was caused by a tumor. Wangenstein¹¹ quotes Kasemeyer, who found that 38 percent of 204 tumors which caused intussusception were malignant.

Four types of intussusception are commonly described:

- (1) *Ileo-ileal*, in which small bowel invaginates small bowel.
- (2) *Ileocecal*, in which the ileum and ileocecal valve pass into the cecum.
- (3) *Ileocolic*, in which the ileum alone passes through the ileocecal valve.
- (4) *Colocolic*, in which a portion of colon is telescoped into another portion of the colon.

The second type is the most common, in which ileum and ileocecal valve enter the cecum. In our series, three of the four cases were colocolic and the fourth was ileocecal.

SYMPTOMS

The cardinal symptoms of intussusception are four in number: (1) periodic pain, (2) vomiting, (3) blood in the stool, and (4) a palpable tumor. In only one of our cases were all four symptoms present. Although many cases of intussusception in the adult have symptoms of acute bowel obstruction, a large number of cases follow a chronic course which may simulate, among other conditions, cholecystic disease, peptic ulcer, or appendicitis. All of our cases were of the chronic variety, which suggests that the intussusception was recurrent or the obstruction incomplete. Diarrhea was noted in three cases and vomiting was a late symptom in two of our series.

DIAGNOSIS

Roentgenographic examinations of two of our patients demonstrated intussusception (see plates), and a third case showed obstruction to the passage of barium by enema with evidence suggestive of intussusception. Recent reports, most of them in foreign journals, outline technics and features in the roentgenographic diagnosis of intussusception. Saint⁷ believes that roentgenograms are of value chiefly because they localize the lesion for subsequent surgery. Attempted reduction of an intussusception in an adult by a barium enema with fluoroscopic observation should never be undertaken because: (1) the lesion causing the intussusception usually persists, (2) even if the reduction succeeds, intussusception will probably recur, (3) the gut wall may be weakened, especially in those cases of intussusception caused by inflammation of the bowel, and increased pressure within the gut lumen may produce perforation with peritonitis, and (4) a malignant lesion may not be recognized.

TREATMENT

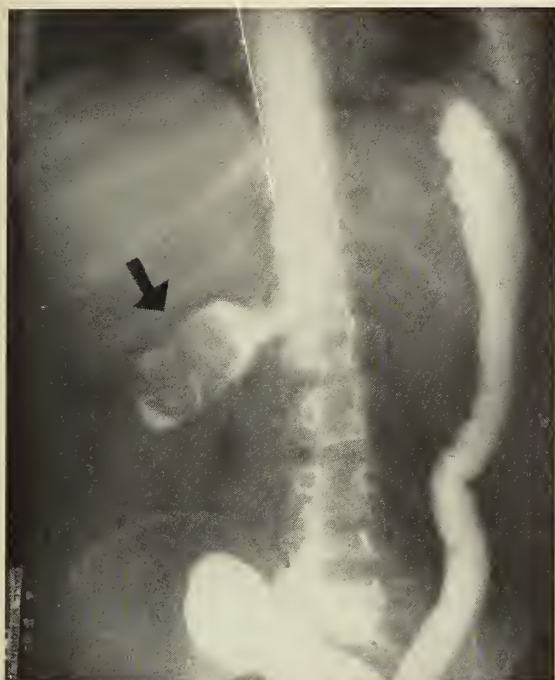
The treatment of intussusception in the adult, when caused by tumor, is surgical, and the commonest operation is that of manual reduction of the intussusception and excision of the tumor with the segment of bowel to which it is attached. Manual reduction of the intussusception may be impossible in some cases. In these, resection of the gut involved is necessary. Ordinarily the operator chooses an exteriorization procedure such as the Mikulicz operation, in which the loop of bowel is brought through the abdominal wall to lie outside the abdomen and the lesion excised. If the intussusception has not produced obstruction and has not disturbed the normal physiology of the adjacent gut wall, a resection of the tumor with the surrounding segment of bowel and a primary anastomosis of the free ends of the gut are indicated. Mikulicz type resections were performed in treating each of our four cases, the double-barreled colostomy being closed in from three weeks to nine months following the first stage operation.

CASE REPORTS

Case 1.

A 45 year old, white housewife was admitted to Ball Memorial Hospital complaining of diarrhea and cramp-like abdominal pain. There had been periodic

Figure 1



Case 1. Roentgenogram taken after evacuation of barium enema showing displacement of barium by tumor and annular folds of intussusception outlined by barium.

Figure 2



Case 1. Roentgenograms similar to figure 1 taken 3 hours later demonstrating change of position of tumor.

episodes of diarrhea, lasting for two or three days during the previous several years. The son and mother of the patient had also experienced repeated attacks of diarrhea. Three weeks before admission the patient was seized by sudden, acute, cramping, recurrent, abdominal pain, accompanied by frequent watery stools. She noted no melena and had not vomited, but her pain and diarrhea became progressively worse.

On examination the patient was a well developed, healthy-appearing, middle-aged woman whose temperature, pulse and respiratory rate and blood pressure were within normal limits. There were no abnormal physical findings. The abdomen was devoid of masses or tenderness. Sigmoidoscopic examination of the rectum and distal sigmoid colon revealed no abnormality. The urine was normal. The concentration of hemoglobin was 72 percent (Sahli); erythrocytes numbered 3,390,000 and leukocytes 15,050 in each cubic millimeter of blood. The differential leukocyte count revealed 78 percent neutrophils with 17 nonsegmented and 61 segmented forms. Microscopic slide agglutination reactions to antigens, prepared from bacteria of the typhoid, paratyphoid and brucella groups, were negative. The Mazzini test for syphilis was negative. The stool was semisolid and was colored green and there were slight amounts of mucus, occasional leukocytes and erythrocytes. No vegetable cells, parasites or pathogenic bacteria were found. Scratch skin tests for food allergy were positive for almonds, bananas, barley and coffee. Roentgenographic examinations of the upper gastrointestinal tract were negative, but a barium enema revealed an obstruction at the middle of the transverse colon. It was the opinion of the radiologist that the obstruction was caused by a pedunculated tumor, probably a lipoma, which had caused an intussusception (see figures 1, 2 and 3).

Exploratory laparotomy revealed an intussusception involving the ascending colon and the proximal transverse colon. This was reduced with moderate difficulty and a mass was palpated within the ascending colon. A first stage Mikulicz operation was done with the removal of a small portion of terminal ileum, the cecum, and ascending colon. The colostomy was closed one month later.

Examination of the surgical specimen revealed a pedunculated lipoma measuring 5 centimeters in length x 3.5 centimeters in average diameter, arising in the mucosa of the ascending colon. This tumor had caused the intussusception and subsequent obstruction of the colon.

This patient is in good health and has had no further gastro-intestinal difficulty.

Case 2.

A 62 year old, white, male farmer was admitted with complaints of diarrhea and of passing blood by rectum. For as long as he could remember this man had had liquid stools, but his diarrhea had become more pronounced in the previous twelve months, and especially so in the previous five days. Streaks of bright red blood in his stools and a "soreness in the bowels" had caused him concern. Although he had lost forty-six pounds during the prior four weeks, he experienced only occasional distention, and suffered no pain or nausea. Histories of his personal and family health were noncontributory.

On examination the patient was robust and appeared well. There was a small umbilical hernia and an indefinite firmness in the lower abdomen, with moderate tenderness in the left lower quadrant. Sigmoidoscopic examination as high as the first loop of the sigmoid colon revealed no abnormality. The urine was normal. The concentration of hemoglobin was 84 percent (Sahli); the erythrocytes numbered

Figure 3



Case 1. Oblique roentgenograms taken after air injection, or "double contrast" study, illustrating translucency of tumor.

4,300,000 and the leukocytes 9,300 in each cubic millimeter of blood. The differential leukocyte count revealed 66 percent neutrophils with 33 nonsegmented and 33 segmented forms. The concentration of serum protein was 6.4 grams in each 100 cubic centimeters of serum and the ratio of albumin to globulin was as 1.66 is to 1. The Mazzini test for syphilis was negative. The stool contained numerous erythrocytes, few leukocytes and no parasites. Roentgenographic examinations of the upper gastrointestinal tract were negative. Barium enemata repeatedly demonstrated a dilated rectum and distal sigmoid colon with a complete barrier to the retrograde passage of barium in the lower sigmoid colon. This obstruction was suggestive of an intussusception.

At exploratory laparotomy a large, freely-delivered mass was found in the sigmoid colon. This appeared to be an irreducible intussusception and a first stage Mikulicz resection of the sigmoid colon was done. The colostomy was closed nine months later. Examination of the surgical specimen revealed a segment of large bowel which appeared to have formed an intussusception. Attached to the mucosa of the intussusception was an ulcerating, sessile, papillary, polypoid adenocarcinoma, involving all but 3.5 centimeters of the circumference of the bowel. This appeared to have preceded the remainder of the intussusception into the intussusciens. The patient is well after four years.

Case 3.

A white, male factory worker, aged 39 years, entered the hospital with vague pain in "the pit of the stomach." He had developed constipation and "bloating" three years before. Four weeks prior to admission he was awakened by a pain in his epigastrium. This pain was recurrent but of short

duration and was similar to "gas pains." The patient complained of nausea on only one occasion and there was no vomiting or melena. Constipation persisted and the patient lost ten pounds. The past and family histories of the patient revealed nothing of significance.

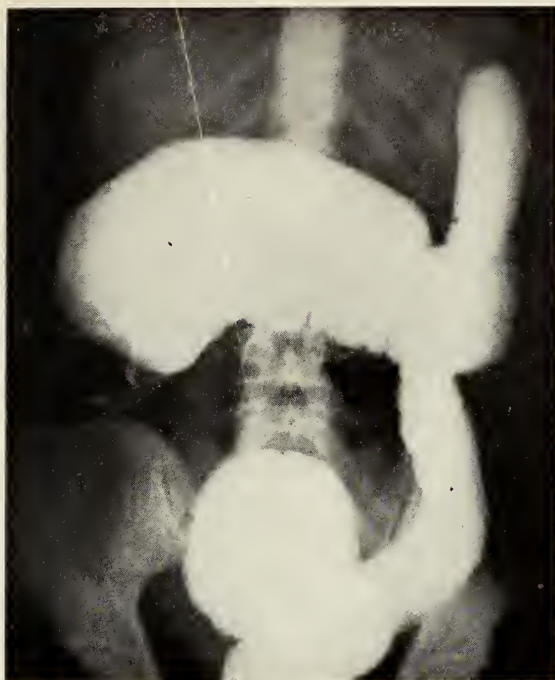
At the time of examination, the patient's temperature was 100.8° F., and the pulse and respiratory rates and blood pressure were within normal limits. The abdomen was poorly relaxed and a vague, generalized tenderness was noted. The urine was normal. The concentration of hemoglobin was 71 percent (Sahli); the erythrocytes numbered 3,500,000 and the leukocytes numbered 44,000 in each cubic millimeter of blood. The differential count was within normal limits. Agglutination reactions to antigens prepared from bacteria of the typhoid, paratyphoid and brucella groups were negative. The Mazzini test for syphilis was negative. Roentgenographic examinations of the upper gastro-intestinal tract were negative; the colon was not examined. A diagnosis of recurrent appendicitis was made. At laparotomy an ileocecal type of intussusception was discovered, with a mass approximately 4 centimeters in diameter within the cecum. A Mikulicz operation was done in two stages, with complete recovery of the patient. He has remained well for four years.

Examination of the surgical specimen revealed a polypoid lipoma arising in the cecum at the margin of the ileocecal valve. This lipoma had produced the intussusception.

Case 4.

A 34 year old, white housewife was admitted to the hospital because of diarrhea and rectal bleeding, nausea and vomiting, pain in the abdomen and weakness. The onset of her illness had been six months before admission (at which time she was four months pregnant), with gripping upper abdominal pain and diarrhea, followed by vomiting. She suffered intermittently until her baby was born two months prior to admission. A bilateral tubal ligation was done early in the postpartum period. There was no improvement in the patient's condition following delivery. She lost weight, became weak, and passed moderate amounts of bright blood in her stools. Her pain continued and was centered in her upper right abdomen. She had always been well prior to her present illness. Her mother had died of cancer of the bowel, and three members of her mother's family had died of cancer. When examined the patient weighed 100 pounds. The tongue was dry and the skin was dry and wrinkled. The abdomen bore a recent, healed, low midline scar and generalized abdominal tenderness was noted. A hard, smooth, nontender mass 7 centimeters in diameter was palpated in the right hypochondrium. The urine was normal. The concentration of hemoglobin was 78 percent (Sahli); the erythrocytes numbered 4,250,000 and the leukocytes numbered 8,000 in each cubic millimeter of blood. The differential count revealed 19 percent lymphocytes, 5 percent monocytes and 76 percent neutrophils, with 23 percent nonsegmented and 53 percent segmented forms. The concentration of serum protein was 6.8 grams in each 100 cubic centimeters of serum. Roentgenographic examinations of the colon were interpreted by the radiologist as being characteristic of intussusception at the hepatic flexure of the colon, with a tumor very probably present (see figures 4, 5 and 6). At operation the hepatic flexure appeared to be a portion of an irreducible intussusception, and there were multiple enlarged, firm mesenteric lymph nodes. The terminal ileum, cecum, ascending colon and one-half the transverse colon were exteriorized and resected. The colostomy was closed eighteen days later and after two years the patient is in excellent health with no evidence of recurrence.

Figure 4



Case 4. Roentgenograms taken before evacuation of barium enema showing obstruction at the hepatic flexure.



Case 4. Roentgenograms taken after evacuation of barium enema showing intussusciptions silhouetted against barium-containing bowel.

Examination of the surgical specimen revealed an obstructing adenocarcinoma, grade 1, of the hepatic flexure of the colon and an adjacent adenoma with adenocarcinoma, grade 1. There was no evidence of regional lymph node involvement. The larger carcinoma had caused the intussusception.

SUMMARY

Four cases of intussusception in adults are reported, all caused by tumors, two of which were lipomata and two of which were carcinomata. Diagnosis was made preoperatively by roentgenography in three cases, and all recovered satisfactorily after two-stage Mickulicz procedures.

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Figure 6



Case 4. Double contrast study after the injection of air showing intussusciptions silhouetted against air-containing bowel.

OBSTETRICAL HEMORRHAGE*

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IN ALL of the numerous and highly instructive reports of maternal mortality which appear from time to time, hemorrhage inevitably occupies a place of signal importance. Further, the inevitable conclusion is that deaths from this cause are almost invariably preventable. In a recent summary from Brooklyn, New York, the following case is recorded: A primipara was delivered by low forceps under ether anesthesia after eight hours of labor. Bleeding actively, she was returned to bed, where she expelled large clots of blood over a period of two hours. Plasma and intravenous glucose were administered and finally the vagina was packed. Cut-downs for another infusion were unsuccessful. Death occurred four hours after delivery; no blood was transfused, the uterus was not explored, and no proper effort was made to stop the bleeding. Of five maternal deaths which were recently considered by the Maternal Mortality Committee of Chicago, three were due to hemorrhage. All of these were judged preventable.

There are two important features which distinguish obstetrical hemorrhages, and which render them peculiarly lethal; first, they are rarely anticipated, and second, the source of bleeding is relatively inaccessible. Since obstetrical hemorrhage, in greater or lesser degree, is so extremely common, it is of the greatest importance that all who handle obstetrical patients keep well in mind a decisive plan of action for dealing with this serious hazard. It is the purpose of this paper to consider the more common obstetrical hemorrhages, and to outline a plan of attack which has been found satisfactory.

BLOOD REPLACEMENT

In obstetrical hemorrhage there is one fundamental, all-important point which has been so heavily emphasized that it should be obvious to everyone, but which, paradoxically, is the most greatly neglected of all. This concerns *blood replacement*. It hardly need be mentioned that plasma or glucose cannot replace blood. To be sure, they are often of great use as a temporary expedient, to be used while blood is being made available, but in the presence of hemorrhage an immediate effort must be made to obtain blood. Very recently the transfusion of blood to obstetrical patients was greatly

simplified by the work of Doctor Diamond of Boston. At the present time it is possible to pool blood, to neutralize the A and B agglutinins, and to make such pooled blood available and compatible for all recipients so far as the basic blood groups are concerned. By providing two blood pools, one of them Rh positive and the other Rh negative, it is possible to provide blood instantly. Where the recipient's Rh factor is unknown, the Rh negative pool may be employed without cross matching until the Rh factor is determined. In many maternities it is the policy at the present time to keep on the obstetrical floor a pint of this Rh negative blood so that it may be immediately available in the presence of hemorrhage. Very exceptionally reactions may occur to such pooled blood. However, when blood is urgently needed its use is considered infinitely preferable to awaiting a routine cross matching.

One other point is worthy of emphasis. When hemorrhage begins or is anticipated, it is well to start an infusion of glucose or plasma, to employ a large needle, and to place this deeply in a vein of the forearm so that, if necessary, it may remain in place for a number of hours, and may be employed at a moment's notice for the purpose of blood transfusion. Very recently Dr. John Cole of the New York Hospital described a method of rapid blood transfusion which makes use of a very simple pressure apparatus consisting essentially of a blood pressure bulb, an aneroid sphygmomanometer and a Baxter transfusion set. By this means and with due care to prevent introduction of air into the circuit when all the blood has run in, it is possible to give as much as 500 cc. of blood through a 15 gauge needle in about three or four minutes. In a recent case which was treated in Baltimore, an abdominal pregnancy, the tremendous amount of 8,000 cc. of blood was given within four hours. The patient's survival is attributed to the fact that she received this huge amount of blood over a short period of time.

In connection with transfusion, it should be mentioned that when hemorrhage is in progress, and there is circulatory collapse such that an infusion cannot be instantly and readily started in the customary veins of the forearm or antecubital fossa, no further time should be wasted, but rather one should proceed immediately to the insertion of a permanent or Hendon-type needle by cutdown. *The most satisfactory and most readily accessible vein for this purpose is the great saphenous vein at the ankle just anterior to the medial malleolus.*

* Read at the meeting of the Fort Wayne County Medical Society, May 6, 1948.

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FIRST TRIMESTER

When bleeding occurs during the first trimester, there are three conditions which must be considered; these are spontaneous abortion, hydatid mole and tubal pregnancy. To be sure, such conditions as cervical polyp or deep erosion of the cervix may also give rise to bleeding; but it is unsafe to consider these possibilities until the more serious ones have been ruled out.

ABORTION

The most frequent type of bleeding which the physician is called upon to manage is that which is due to *spontaneous abortion*. In only about 5 per cent of such cases is bleeding sufficiently serious to demand consideration. In this group there is difference of opinion concerning the wisdom of curettage. In many medical schools today it is adamantly taught and practiced that incomplete abortion should invariably be handled "conservatively," without curettage. Opposed to this teaching are those who curette almost immediately upon the appearance of any bleeding which exceeds that equivalent to a normal menstrual period. My own position parallels that which was recently outlined by Pratt, of the Mayo Clinic. When bleeding is severe, irrespective of fever or other so-called contraindications, the uterus must be emptied immediately, and appropriate supportive measures begun. When bleeding is only moderate the patient may be observed for a short period in the hope that the abortion will be completed spontaneously. Ergonovine (0.2 mgm.) should be given intramuscularly at once and four times daily by mouth. The patient should remain in bed and any anemia corrected by blood transfusion or iron therapy as may seem appropriate. Provided there is no increase in bleeding, this observation may be continued up to 48 hours. If active, even though moderate, bleeding continues at the end of this time the patient is taken to the operating room and prepared for curettage. Not infrequently, when the cervix is exposed, the products of conception are found to be protruding from the external os. If this is the case, they may be grasped with an ovum forceps and gently twisted out, so completing the abortion. Ordinarily, however, one is not so fortunate. On examination, the cervical canal is generally already dilated, but if not, this is readily accomplished because of the marked softening of the cervix. A small ovum forceps or a curved sponge forceps is then introduced through the cervical canal and is gradually opened as the instrument is being introduced into the uterine cavity. When one encounters the fundus of the uterus the instrument is then closed and gently turned as it is being withdrawn. By this means the greater part of the retained products of conception are generally evacuated. The uterine wall is then gently and systematically curetted, employing for this purpose a *large, sharp curette*. I see no virtue in the dull curette, and in fact consider it an ineffective and dangerous in-

strument. A sharp curette employed gently and carefully imparts to the operator a knowledge of the type of tissue he is curetting, and for this reason the danger of perforation of the uterus seems far less than if a dull curette is employed. When the systematic curettage is completed, ovum forceps are again employed in the manner indicated and any detached fragments so removed from the uterine cavity. Pitocin or ergonovine are now given. Plain gauze packing may be inserted at the discretion of the operator, although it is rarely necessary if the uterine cavity has been emptied.

HYDATID MOLE

Hydatid mole is characteristically suspected when the uterus during the first trimester is larger than it should be in accordance with the patient's menstrual date. Bleeding is common. It is ordinarily not heavy, although in one of the cases considered by the Chicago Maternal Mortality Committee, the hemorrhage from a hydatid mole was dramatic and fatal. The patient's life would have been saved by transfusion and curettage, neither of which were done. The passage of an edematous, grape-like chorionic villus makes the diagnosis. Once such a pathognomonic sign appears, it is proper and indicated to perform immediate curettage irrespective of whether bleeding is present. However, one must be wary of making a diagnosis of hydatid mole unless one has actually seen a hydropic villus, and must not proceed to curettage merely upon the strength of bleeding in a uterus which is larger than it should be by dates. Occasionally in such a case one may be chagrined to find that the menstrual history is inaccurate, and that instead of evacuating a hydatid mole one is in truth attempting to deliver a four months' fetus by curettage.

SECOND TRIMESTER

Very fortunately *abortion in the middle trimester of pregnancy* is extremely rare, and when it does occur, bleeding is not often an important feature. When bleeding does assume alarming proportions, however, as it does in certain cases of placenta praevia, management may be extremely difficult for the reason that the relatively simple procedure of curettage cannot be safely performed. By the time pregnancy passes the third month, the diameter of the fetal head is great enough that it cannot be delivered through the amount of cervical dilatation which may be procured by the Hegar or Goodell dilators. In these cases one should make every effort to induce labor by small doses of pituitrin. No attempt should be made to interfere from below. Where serious bleeding occurs, abdominal hysterotomy is greatly preferable to the difficult and time-consuming manipulations which are so often necessary for the vaginal delivery of a five or six months' fetus in the presence of heavy bleeding.

ECTOPIC PREGNANCY

The textbook syndrome of *tubal pregnancy* is well known, and I do not wish to consider the subject in detail. However, one point which I believe is not sufficiently emphasized is that the syndrome is rarely as typical as one would believe from casual experience. Characteristically one finds a history of pregnancy of about two months' duration, vaginal spotting, and pain in one of the lower quadrants. Very recently I was called to the home of a young woman who was in approximately the second month of her first pregnancy. As I was passing the bathroom I caught sight of a small pile of blood-drenched underthings. With this evidence of sudden, copious hemorrhage, I made a mental note of incomplete abortion, an impression which was strengthened by subsequent inquiry. The patient was admitted to the hospital, at which time bleeding had stopped. While the advisability of curettage was being considered, she suddenly complained of excruciating abdominal pain and promptly went into shock. Blood was transfused, and at operation immediately thereafter a ruptured tubal pregnancy was found. Vaginal bleeding such as occurred in this patient is extremely unusual in tubal pregnancy; but the mere fact that external hemorrhage occurs does not rule out the possibility.

THIRD TRIMESTER—PLACENTA PRAEVIA

Of all obstetrical hemorrhages, by far the most spectacular are those which are due to *placenta praevia*. Bleeding due to this cause characteristically occurs first from two to four weeks before term, is apt to be quite copious, and is painless. The treatment of this condition during recent years has undergone a dramatic change. Until a few years ago it was generally believed that once a diagnosis of placenta praevia had been made, instant delivery was indicated. In 1945 two papers appeared, one by Johnson and one by McAfee, which exploded the previous therapeutic rationale. These papers demonstrated by a survey of large numbers of cases of placenta praevia that in this condition *the first vaginal hemorrhage is rarely if ever fatal in the absence of vaginal manipulation*. Further, they showed that *subsequent hemorrhages were rarely if ever fatal in the absence of vaginal manipulation provided the hemoglobin is normal at the onset of hemorrhage*. At the Johns Hopkins Hospital Dr. Nicholson J. Eastman analyzed a series of 304 placenta praevias with the purpose of investigating the validity of these contentions. A study of these cases revealed that *in no single instance was an initial hemorrhage fatal except after extensive vaginal manipulation*. He found further that in no single instance was subsequent hemorrhage fatal except after vaginal manipulation. These observations should not diminish one's respect for hemorrhage. Rather, they should form the basis for a rationale of therapy which is extremely simple and which, if strictly followed, will virtually eliminate the danger of serious hemor-

rhage from placenta praevia. First, it should relegate to oblivion the frequent practice of vaginal examination or vaginal packing before transporting a patient to the hospital. When active bleeding occurs in the last trimester of pregnancy the patient should be advised to remain absolutely quiet while arrangements are being made to transport her to the hospital, which should then be accomplished by the most expeditious means. The patient's course, after being admitted to the hospital, will depend upon the amount of bleeding, the viability of the baby, and whether or not labor has begun. Parity is of little interest. These various factors cannot be separated from one another and in evaluating a case of placenta praevia they must all be considered together. At the outset may I emphasize that present opinion is strongly against the still common practice of haphazard vaginal examination in order to determine the presence or absence of placenta praevia. It is also worthy of emphasis that leaders in the field of obstetrics, and also those who have recently concerned themselves with this problem, recognize only three types of therapy for placenta praevia. These are (1) observation, (2) cesarean section, (3) rupture of the membranes.

Since it has been amply demonstrated that bleeding in placenta praevia without vaginal examination is rarely fatal, it has been advocated that *under certain circumstances* the patient may be observed in the hospital for a time. The most frequent circumstance under which one would wish to do this is when the baby is premature. Thus in the presence of active, painless bleeding, for example in the eighth month of pregnancy, one might elect to observe the patient in the hope that the pregnancy might be continued until such time as viability is achieved. It goes without saying that such observation should be carried on only in a hospital where the house staff is alert, when the initial hemorrhage stops, and where there are adequate facilities for instant transfusion of blood and for very close daily observation of the patient's blood loss and hemoglobin. *No vaginal examination should be made*. It is true that the bleeding may not be due to placenta praevia; but the danger of finding out so far outweighs the inconvenience to the patient that vaginal examination under these circumstances is considered inappropriate. Occasionally such patients may be carried for several weeks without intervention of any kind. Occasionally a second or third hemorrhage may occur; but if they stop spontaneously and if the hemoglobin levels are closely watched and maintained at a high level their danger is not great. Obviously, if bleeding is alarming or does not stop within a reasonable period, one must proceed to immediate delivery, irrespective of viability.

It will be observed that the acceptable forms of therapy which were mentioned above do not include such measures as the Voorhees bag, Braxton Hicks version, and tamponade. Indeed, they are condemned. The colpeurynter was introduced by Doc-

tor Voorhees at the Sloane Hospital for Women in New York, and for many years found great popularity in that institution as well as elsewhere. In a recent study from the Sloane Hospital, in which 79 placenta praevias were analyzed, it was concluded that the Voorhees bag was one of the most lethal measures which was available for the treatment of placenta praevia. A significant drop in mortality from this cause was observed during the more recent years when the bag has been in disfavor. Also of interest in this connection are Eastman's figures. In a recent study from Johns Hopkins, 57 percent of all placenta praevias were delivered by cesarean section. This is to be contrasted with a former incidence of from 3 to 7 percent of placenta praevias treated by section. The great increase in the use of cesarean section is accompanied by a drop in the maternal mortality from a former level of 14 percent to a present mortality of 0.9 percent. The fetal loss also dropped from 78 percent to 46 percent. On our own service at the Evanston Hospital in the past five years we have had 64 cases of placenta praevia with no deaths; 53 percent were delivered by cesarean section. The elimination of the bag and Braxton Hicks version as acceptable procedures is considered an extremely important factor in obtaining these very favorable results. Doctor Eastman concludes from his study that cesarean section should be employed in all cases of placenta praevia except certain cases of the marginal type. In the latter one often finds bleeding which is less spectacular than in the central, and very frequently, in addition, the uterus is extremely irritable, and on rectal examination a portion of the head can be felt through a 2 or 3 cm. cervix. In cases such as this simple rupture of the membranes allows the head to come down against the placenta, and labor which generally is uneventful ensues. If bleeding continues despite rupture of the membranes it is permissible to employ Willett's scalp forceps and by this means gently to advance the head against the placenta. But in the event that one deals with any type of praevia other than a marginal or partial one, or where bleeding is not controlled by these simple measures, cesarean section is considered advisable. In this connection it may be mentioned in passing that in the hands of very skilled obstetricians cesarean section is a far simpler procedure than a difficult delivery from below. For the inexperienced or casual obstetrician this is even more true.

To summarize the treatment of placenta praevia, I believe very strongly that in the case of active, painless bleeding at or before term, where the bleeding is profuse or does not stop within a reasonable period, immediate cesarean section should be performed without prior vaginal examination. Also in the patient at term with a profuse painless hemorrhage, even though it be momentarily stopped, cesarean section without prior vaginal examination is also indicated. If this course is followed, approximately 60 percent of cases of placenta praevia

will be treated by section. The remainder, those in which simple rupture of the membranes is indicated, are those in which the initial hemorrhage is not severe and the head on abdominal examination is deep in the pelvis. If these two conditions are present one may examine the patient rectally, gently. If the cervix is effaced and partially dilated, indicating that vaginal delivery would occur within a short period, and the head is presenting and engaged, one may then rupture the membranes. But if there is discrepancy in any of these points one should incline strongly toward cesarean section.

PREMATURE SEPARATION

The other major bleeding complication of the last trimester of pregnancy is *premature separation of the placenta*. It will be recalled that in this circumstance the placenta may be completely or only partially detached from the uterine wall, and the effused blood may be entirely retained within the uterine cavity or it may escape externally through the vagina. In the case where the placenta is only partially detached, and where the entire amount of bleeding issues from the vagina, especially if the patient is already in labor, the danger of this condition is slight. On the other hand, complete detachment of the placenta, irrespective of the direction of bleeding, is one of the most serious accidents of pregnancy and labor. It is serious not only because of the potentialities of the situation itself, but its hazard is further increased by the fact that one deals with a dead baby, and one's analysis of the problem is necessarily affected by this knowledge. In short, with a living baby one would not hesitate to perform a cesarean section, which would not only offer the best chance of obtaining a living child, but would constitute definitive treatment of the separated placenta. But too frequently one is reluctant to perform cesarean section when the baby is dead even though his better judgment dictates this as the only proper method of dealing with the potential catastrophe. When the patient is not in labor, and where the cervix is not dilated enough to assure an effective induction of labor by simple rupture of the membranes, cesarean section is the only proper means of dealing with this condition irrespective of whether the baby is living or dead. If labor has begun and the cervix is partially dilated, and if it appears that progress will be rapid, one may observe the patient and limit interference to rupture of the membranes. However, one must follow the dilatation of the cervix very carefully and be prepared to intervene by cesarean section at a moment's notice if there is evidence of fetal distress, of improper progress of labor, or an increase in bleeding. In the case of either placenta praevia or premature separation, it goes without saying that one must not begin to operate, either abdominally or vaginally, until blood is available and transfusion is actually begun. Furthermore, sufficient excess blood should be available to replace

instantly any loss which may accompany the procedure.

POSTPARTUM HEMORRHAGE

The final obstetrical hemorrhage which I wish to discuss is *postpartum hemorrhage*. It has been estimated that of every 3,300 deliveries one patient dies of postpartum hemorrhage. The incidence of postpartum hemorrhage is variously estimated at from 4 to 6 percent of all deliveries. Ordinarily, postpartum hemorrhage is sudden, dramatic, profuse, and unanticipated. But there are certain conditions which should make one alert to the possibility that it may occur. For example, it is well known that excessive bleeding frequently follows multiple pregnancy and hydramnios, because the uterus has been excessively distended. It is also frequent in precipitate labor and very prolonged labor. In these circumstances serious hemorrhage may occur, and one should be particularly watchful.

The conduct of the third stage of labor is extremely important in the prevention of postpartum hemorrhage. In recent years much has been written concerning the physiology of the third stage. One very important recent addition to our knowledge concerning this is the observation that separation of the placenta begins during the second stage of labor, and that the signs which were formerly thought to be those of separation, chiefly an asymmetrical enlargement of the uterus, are merely due to the accumulation of blood within the uterus. At the present time most men who have concerned themselves with the management of the third stage advocate early expression of the placenta. Our own practice, which has been eminently successful, follows this recommendation. Immediately after the baby is born an assistant holds the fundus of the uterus. At this time the uterus is found to be flabby, and flattened anteroposteriorly. During the next minute or so the uterus becomes harder, and its shape changes from discoid to globular. When this firm, globular shape is felt, the cord is held firmly but without excessive traction, and a gentle Crede expression is begun. If the placenta does not advance immediately, the uterus is pulled away from the cord, which is held taut. By this means the placenta is ordinarily caused to leave the uterus and to enter the vagina. Employing this maneuver the average duration of the third stage is from two to four minutes. If the placenta is not immediately obtained in this manner one should not continue his efforts to deliver it, but rather should await a second or third firm contraction of the uterus. Some clinics recently have advocated manual removal of the placenta within ten or fifteen minutes if it cannot be expressed. I believe that in the absence of excessive bleeding this procedure is not indicated, but should be reserved for cases in which there is excessive bleeding, or in which the placenta has not been delivered within

an hour's time. As soon as the third stage is complete, the patient is given 1 cc. of ergonovine intravenously. Many have advocated the use of ergonovine intravenously as soon as the baby's anterior shoulder appears. My own experience with this has been that incarceration of the placenta is somewhat more frequent, and that bleeding is not diminished over the procedure which we have employed.

It is immediately after the completion of the third stage that one most frequently encounters postpartum hemorrhage, and one's action during this brief period is often of the greatest significance insofar as the appearance of dangerous hemorrhage is concerned. Once bleeding does begin after the ergonovine has been given and has failed to take effect, bimanual massage of the uterus should be done with two fingers, or occasionally with the entire fist, pressing against the anterior aspect of the uterus vaginally, and the fundus and posterior aspect of the uterus being brought down against this vaginal hand abdominally. Very vigorous massage may be made, and hemorrhage will almost invariably be checked by this measure. In addition, at this time it is our practice to give pitocin intramuscularly, and to give 10 cc. of 10 percent calcium gluconate intravenously. It has been shown both clinically and experimentally that the irritability of the uterus is greatly increased by calcium. *We have had several cases in which the uterus failed absolutely to react either to ergotrate or to pitocin or to both, in which immediate sustained contractions of the uterus followed the administration of calcium intravenously.*

I have not mentioned uterine tamponade in the treatment of postpartum hemorrhage, for the reason chiefly that I have never had occasion to use this measure, and never expect to. I have been interested recently to see the articles of Cosgrove, of the Margaret Hague Maternity Hospital, and of Eastman, which condemn the procedure, not because of the possibility of infection, but rather because it is considered as ineffective. Bleeding due to uterine atony can be controlled invariably by the measures which have been outlined above.

In the event that bleeding continues despite a firmly contracted uterus and an intact placenta, the implication is that its source is a laceration of the birth canal at some point. At the Evanston Hospital it is our routine to include in the delivery setup two wide Jackson retractors and two ring forceps. When these are properly employed the cervix may be readily inspected, and in fact should be routinely inspected in all deliveries irrespective of bleeding. The common practice of packaging retractors separately and employing them only occasionally creates a mental hazard which may defer examination of the cervix for a long enough period to allow significant blood loss.

One final point of great importance which is often overlooked is the necessity for observation of the

patient at least until she has completely reacted from her anesthesia. Not infrequently patients are returned immediately to the obstetrical floor, serious hemorrhage occurring before there is full reaction from anesthesia. Before the patient is left alone one should be satisfied that the pulse is within normal limits, the blood pressure is normal, the fundus is firm and at a proper level in the abdomen,

that bleeding is within normal limits, and that she is fully reacted.

In conclusion, may I emphasize again that in dealing with any type of excessive bleeding due to obstetrical causes, whether this be merely somewhat greater than normal or whether it be hemorrhage, one's first thought must be replacement of the blood and anticipation of further blood loss.

TETRAETHYL AMMONIUM CHLORIDE AND ITS USE IN THE PERIPHERAL VASCULAR DISEASES

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WE WISH to present in this study observations on the effects of tetraethyl ammonium chloride given parenterally to over one hundred patients suffering from a variety of disorders. Only seven cases are herein reported in detail.

The pioneer work was done by Acheson and Moe.^{1, 2} They used the bromide salt. The chloride salt is now used to eliminate symptoms of bromism. A 10 percent solution has been found to be the most satisfactory. The dosage of the drug varies between 0.1 and 0.5 Gm. (not to exceed 7 mg. per Kg. of body weight) intravenously, and up to 1.2 Gm. (not to exceed 20 mg. per Kg. of body weight) intramuscularly. Intramuscular injection produces burning at the site of puncture which lasts for about two hours. The intravenous route is the one preferred by us. A maximum effect is produced with 0.1 to 0.2 Gm. intravenously; larger doses cause a prolonged effect. The speed of injection, as well as the route and total dosage, played a part in the extent of the pharmacological effect. A rapid injection of a small amount will produce all the effects, but they wear off more rapidly. A large dose intramuscularly may not produce all the effects because of slow absorption, but they will be prolonged. Also there is the patient factor. Some patients will get a greater and longer response than others with the same dosage. In one case we produced vasomotor collapse with 0.1 Gm., whereas in most cases 0.5 Gm. was tolerated intravenously.

The site of action was determined by Acheson and Moe^{1, 2} to be on the autonomic ganglia; here it produces a temporary blockade of both parasymp-

athetic and sympathetic nerve impulses. They found that acetylcholine and adrenalin, which act on structures peripheral to the ganglia, were able to antagonize the effects of tetraethyl ammonium salts on structures innervated by parasympathetic and sympathetic divisions respectively.

The clinical effects of the intravenous administration of the drug are almost immediate. During injection a few patients were able to detect, first of all, an increased flow of saliva. This was generally in about twelve to fifteen seconds. This was followed in a few seconds by a metallic taste.*

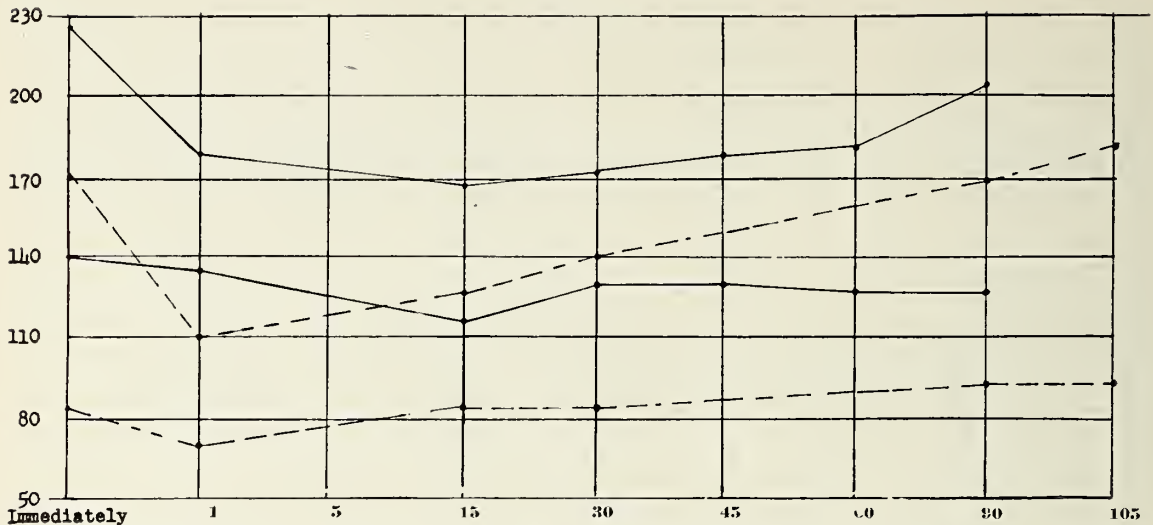
The respiration is quickened momentarily and then becomes deeper and finally settles at normal. Some patients have experienced numbness and coldness in the extremities in 25 to 35 seconds, but most commonly a tingling of the extremities occurs. This is followed by a loss of accommodation. The eyes become heavy (ptosis) and a tired, weak, relaxed feeling is experienced. A fall in systolic and diastolic blood pressures occurs in the majority of patients within 30 to 60 seconds. The greatest drop occurs in hypertensive patients and the least drop in hypotensive individuals. Associated with the drop in pressure is a rise in heart rate. By this time the skin is warm and dry and the mouth becomes dry. The temperature gradient between toes and thighs is generally abolished. Many patients become quite cool after this and some actually have chills. In some, the hands and feet break out in a sweat. Only a few had nasal congestion. In one patient, case number one, this became a very distressing effect from rhinorrhea, but benadryl gave relief.

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* Because of this effect, which is definite and present in most cases, we would like to suggest this drug for use in determining arm to tongue circulation time.

GRAPH 1



See text for explanation. The numbers along the ordinate represent millimeters of mercury blood pressure. The numbers along the abscissa is the time in minutes. I, represented by the continuous line, received 0.1 Gm. of tetraethyl ammonium intravenously. Number II, represented by the intermittent line, received 0.2 Gm. of tetraethyl ammonium intravenously.

After several minutes the blood pressure begins to rise and may go above, reach or stay below the former level. However, postural hypotension persists for some time after the return of the blood pressure to normal and the patient must remain recumbent until this effect wears off. In some cases there is a cessation of forceful gastro-intestinal motility, but in our experience there was no trouble as far as constipation was concerned. None of our patients had difficulty in voiding.

Graph number one indicates the blood pressure response of two different patients plotted over a period of ninety and one hundred and five minutes. In most cases the fall is immediate to a few minutes after injection, followed within about five minutes by a rise in blood pressure. However, in certain cases it was an hour or more before the original blood pressure level was reached. In a few severe hypertensive cases the original blood pressure level was never resumed during the period of observation. It was noted that the intramuscular route has a much more prolonged effect; at the end of thirty minutes the blood pressure continued to fall in most instances.

By the term peripheral vascular diseases we mean any vascular disease outside of the heart itself. In our group of cases we include thromboangiitis obliterans, Raynaud's phenomenon, arteriosclerosis obliterans, sudden loss of sight from peripheral vascular disease in the retina, emboli to peripheral arteries, reflex sympathetic dystrophy, including causalgic states, and Sudeck's atrophy.

Case No. 1 is a report on a 32 year old, white woman, suffering from a causalgic state and reflex sympathetic dystrophy. Six weeks prior to the use of tetraethyl ammonium a postpoliomyelitis deform-

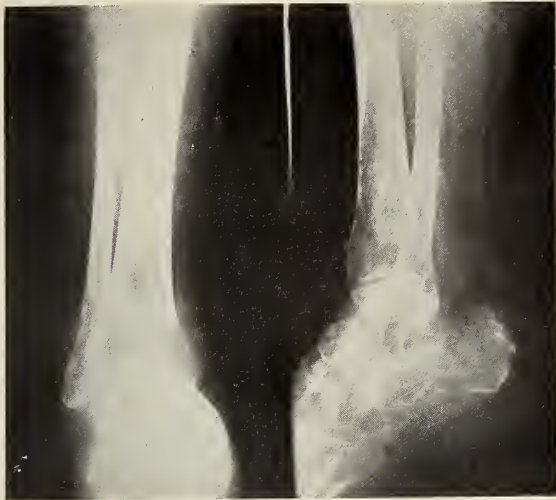
ity of the left foot was operated. Six weeks later, after the cast was removed, the foot was very painful to walk on and excessive swelling persisted even with the use of an elastic bandage and other measures. March type fractures developed at the metatarsal burr hole sites. Vasospasm was evident by hyperhidrosis, pain, coldness, mild cyanosis and blotching of the skin. The foot was not terribly painful when the patient was recumbent and held it elevated.

Tetraethyl ammonium was given intravenously and the typical reactions came on in the usual sequence. After three days it was decided to perform a paravertebral lumbar sympathetic block. This made the left foot much warmer than the right. Whereas previously intravenous injection of tetraethyl ammonium produced tingling and warmth in the right leg first, that night the intravenous injection of the drug produced tingling in both feet at the same time. It seemed to augment the effects of the sympathetic block and increased and prolonged the warmth in the left foot. Similar results and reactions occurred on the next two nights.

Three days after the first sympathetic block was done another one was performed. Daily intravenous doses of 0.4 Gm. of tetraethyl ammonium were given and six days later the left foot was still warmer than the right. This gave great relief of edema, pain and evidence of vasoconstriction.

Case No. 2 is that of a 48 year old, married, white woman, who was admitted because of a comminuted fracture of the proximal end of the tibia. Progress films during the next two months of immobilization did not indicate any appreciable callus. On the third month there was an increase in the amount of callus formation. Seven months after fracture, roentgenograms revealed an extreme degree of osteoporosis in the distal femur and proximal tibia and fibula. The right ankle was examined at this time because of the development of pain, coldness, hyperhidrosis and swelling. This roentgenogram revealed extensive osteoporosis involving the distal tibia and fibula and all the tarsal bones. This was more than could be expected with disuse alone and was considered to be

Figure 1



Roentgenogram of the right ankle of case number 2. See text for explanation.

Sudeck's type atrophy (causalgic syndrome). (See figure one.)

The patient was afraid to move her foot because of pain. Because of this causalgic state tetraethyl ammonium was tried. Remarkable pain relief was obtained. Even while the injection was being given relief was felt. As little as 0.05 Gm. would give relief for awhile. This drug evidently interrupted the afferent impulses of the reflex chain setting up the causalgic state. The increase in warmth and dryness of skin followed. After about two weeks of treatment consisting of diathermy, massage and active encouragement, we were able to get the patient to apply weight and try to walk. At her last visit she was really doing well. She could walk and did not complain of pain, swelling or coldness of her foot and leg.

Case No. 3 concerns a forty year old, single, white male. He was first seen on 7-18-46. His past history was negative except that he started smoking at six years of age and had smoked cigarettes, cigars and pipes ever since.

The pertinent points in his physical examination were a slight clubbing and cyanosis of finger nails and the absence of pulsation of both dorsalis pedis and the right posterior tibial arteries. The right radial artery was barely detectable. The right calf was one inch and the thigh two inches smaller in circumference than the left. The right third toe was absent (surgically anaputated six weeks prior to admission) but the base was open and draining, as was the dorsal distal surface of the second right toe. There was purulent material in the base and about the edges of the ulcer, with an inflammatory reaction around the periphery. The distal third of the foot was reddened, swollen, and very painful to touch.

The oscillometric index on the left popliteal area was 4 and on the right ¼. (See table I.) At the anterior tibial area it was 3 on the left and 0 on the right. The skin temperature was lower all the way up on the right lower extremity than on the left. At the ball of the foot it was 6° C. colder. A right paravertebral lumbar sympathetic block gave great relief. Within thirty minutes the patient was free of pain for the first time in two months. This pain did not recur. The skin temperature increased so that the right lower extremity was warmer than the left.

For four months various therapeutic measures were done which did not produce complete healing of the right second toe.

He was hospitalized for two weeks for daily injections of tetraethyl ammonium. He tolerated 0.5 Gm. intravenously daily. This gave him his greatest relief but a pinpoint draining sinus persisted for sometime. Tetraethyl ammonium 0.5 Gm. was continued at weekly intervals in the Clinic. At the last Clinic visit healing had taken place. Reference to table I will indicate comparative oscillometric and skin temperature studies over a period of one year.

Case No. 4 concerns a 69 year old, white, married man, who was first seen in the Clinic on July 15, 1946. His present difficulty dated ten days prior to admission. He felt there must be a deficiency in circulation, for his right foot was cold and there was soreness in his right foot and calf. When he walked he felt a nettle-like sensation and as if he had cobblestones under his foot. He had never had varicose veins or ulceration of legs. The physical examination was negative except for mild prostatic enlargement and the absence of pulsation of the dorsalis pedis and posterior tibial arteries of both feet. The right great toe was much colder than the left.

Table I. This represents case III. See text for explanation.

	7-18-46		7-18-46		8-4-47		8-4-47	
	Right	Left	Right	Left	Right	Left	Right	Left
Oscillometric Index								
Anterior Tibial Area	0	3			½	3	½	5
Popliteal Area	¼	4			1	3	2	5
Peripheral Pulses								
Posterior Tibial	0	++			0	++	0	++
Dorsalis Pedis	0	0			0	0	0	0
Radial	+	+++						
Skin Temperatures			30 minutes after right lumbar paravertebral sympathetic block					
Ball of Foot	86°	92°	92°	90°	91°	91°	91°	93½°
Dorsum	88°	93°	93°	91°	92°	92°	92½°	94°
Mid-Calf	90°	95°	93½°	92°	95°	92°	96°	95½°
Thigh	91°	95°	95°	92°	93½°	91°	96°	94½°

Table II. This represents case VI. See text for explanation.

	5-12-47		5-18-47	
	Right	Left	Right	Left
Oscillometric Index				
Anterior Tibial Area	1½	0	1½	1½
Popliteal Area	3½	0	3½	2½
Peripheral Pulses				
Posterior Tibial	++	0	++	++
Dorsalis Pedis	++	0	++	++
Femoral	++	+	+++	+++
Skin Temperatures				
Ball of foot	90°	80½°	84°	88°
Dorsum	90°	86°	87°	90°
Mid-Calf	88°	87°	88°	91°
Mid-Thigh			90°	91°

Claudication pain appeared after walking two blocks.

The significant laboratory findings indicated a mild diabetes; films of the feet revealed extensive calcification of the arteries. After the patient was placed on diabetic management his general condition improved, but his foot became worse. He was taking aminophyllin, performing Buerger's exercises and following his diet. Six months after his first visit he was having more pain and tingling in his right foot, and now the left foot was beginning to feel like the right one did when symptoms first appeared. After one week of daily intravenous injections he was feeling definite relief of pain and tingling; the foot felt warmer and as if it had more strength and life in it. He could now enjoy a peaceful night's rest. The patient was seen again after three months of daily tetraethyl ammonium therapy. At this time he stated he was greatly improved; however, his feet were very flushed when dependent, and they blanched quickly when elevated. He had no nocturnal or claudication pain.

Case No. 5 is that of a 45 year old, married lady, who had been seen in our Clinic off and on since 1941. Kidney trouble of one year's duration prompted her first visit. The results of this examination indicated a persistent pyuria due to a large branched calculus in the left kidney pelvis. A nephrotomy was done on June 2, 1941. Pyelograms at intervals revealed blunting of the calyces on the left with some decrease in diodrast dye excretion. This improved as time went on.

She was admitted to the hospital on January 6, 1947, because of loss of vision in the right eye. She was doing well until four days prior to admission when she noticed that the right eye was blurring. There was no pain or soreness. Twenty-four hours later (three days before admission) the right eye was almost totally blind and there was a sense of fullness about the eye. She presented herself desiring to know the cause of her loss of vision.

Examination revealed a normal eye, externally. There was only light and dark perception. Some areas of the field were better than others; the media was clear. The fundus revealed complete closure of the central vein with intense retinal edema, many spots of hemorrhage, a swollen and cloudy nerve head, and great tortuous dark red veins. It was felt that the closure probably resulted from the pressure of the central artery.

Reviewing the patient's old history, she had had a paroxysmal hypertension since first admission. Her present blood pressure was 230/115. There were no other cardiovascular signs or symptoms.

Although pyelograms were again negative, the urine culture produced a staphylococcus that was sensitive to penicillin.

It was felt that it was too late to accomplish a desired result with any form of treatment. We thought that this would be an excellent case in which to try the vasodilating effects of tetraethyl ammonium used in conjunction with dicumarol. The first dose of tetraethyl ammonium was 0.3 Gm. intravenously, which was increased to 0.5 Gm. daily. Penicillin was used parenterally because of the positive urine culture.

One week after admission the patient could detect color and distinguish between men and women out in the hall. There was less edema in the retina. Tetraethyl ammonium was continued until January 17 and dicumarol until January 18, when she went home. Her blood pressure had decreased to remain below 200 systolic.

When the patient was seen on February 3, 1947, she revealed marked improvement. There was 20/400 vision in the right eye. The edema of the retina was mostly gone, and the veins had assumed fairly normal size. Blood pressure was 170/95.

On March 10, 1947, there was 20/200 vision. Objects were seen well. On April 7, 1947, the right eye was still better, with 20/100 vision.

Case No. 6 involves a 74 year old widow, who was admitted as an emergency on May 12, 1947. She had been spading her garden three days before admission and it was directly after this that she first felt pain and coldness in her left foot. This progressed, becoming more cold, painful, and finally useless. Upon admission it was noted that the patient had auricular fibrillation, with a rapid rate. The heart sounds were characteristic of a predominant stenosis at the mitral area and a predominant insufficiency at the aortic area. There were rales over both lung bases; the liver extended two fingers below the costal margin; there was no pretibial edema. The left lower extremity was cold and appeared bloodless and dead. The peripheral pulses did not exist. There was a femoral pulse but of poorer volume and intensity than the right. The oscillometer did not register any deflection, as high as it could be placed, (four inches below Poupart's ligament). Skin temperature determinations indicated a great discrepancy between the two lower extremities.

The clinical diagnosis was that an embolus from a mural thrombus had lodged in the profunda branch of the left femoral artery.

Since this condition had existed for three days it was felt that an embolectomy was not indicated and that we should try tetraethyl ammonium with dicumarol; 0.1 Gm. of tetraethyl ammonium was given soon after admission, without untoward reaction. On each succeeding day for six doses 0.2 Gm. was given intravenously. Two days after admission the left thigh felt much warmer and a popliteal pulse was detected; only the lower leg remained cold and pale blue. The oscillometric index now varied from 1 to 4 (the variation was due to auricular fibrillation) at the popliteal area. There was no oscillation at the anterior tibial area. She had no more pain in her left hip and thigh but her leg still pained. Two days after this (four days postadmission), the left foot was warm but not as warm as the right foot. On the sixth postadmission day the dorsalis pedis and posterior tibial arteries pulsated. The left lower extremity was now warmer than the right and at the ball of the foot it was 4° C. warmer.

Case No. 7, a 54 year old, white, married man, was first seen on 8-1-46. He smoked a package of cigarettes daily. His chief complaints upon admission were weakness, pain and numbness of his lower extremities. The first indication of his present trouble occurred two years previously. If he walked briskly his thighs would feel stiff; then they would pain and his feet would drag. This discomfort was

promptly relieved by rest. This had progressed so that he was unable to walk any distance without rest. For sometime he had been unable to stand on his feet for more than ten minutes because of the above complaints.

The positive physical findings were those referable to his peripheral vascular examination. Neither the dorsalis pedis nor the posterior tibial arteries of either foot were palpable. The oscillometric index over the left anterior tibial artery was 0; that over the right was $\frac{1}{2}$. The popliteal index was $\frac{1}{2}$ bilaterally.

Both feet were cold and the legs revealed definite loss of flesh. The reflexes were hyperactive. There was an absent ulnar pulsation on the left. There was an absence of pulsation in the left radial artery but some blood passed, as evidenced by the Allen test. The blood pressure in the left arm was 85/70 and in the right 125/70. Films of both legs and feet revealed no evidence of arterial calcification; however, lateral films of the lumbosacral spine revealed calcification in the abdominal aorta.

He quit smoking, although this was most difficult for him to do. He noticed later that when he would get around tobacco smoke he would "tingle." He also employed Buerger's exercises and took tetraethion intravenously twice a week. Five months later he did not have the dead feeling in the back of his legs and he could walk a square before suffering a cramp or burning in the calves of his legs. If he would wait three or four minutes he could go on. He had improved so that now he was as good as he had been a full year before he quit work. He had gained in weight, strength and appetite.

The patient was hospitalized for daily injections of tetraethyl ammonium. The feet would become warm and remain so for an hour. They would continue to stay warm if he kept his slippers on. After one week his feet had more feeling and moisture. He could now walk twice as far—two blocks—and suffered no fatigue or cramping.

DISCUSSION

The ability of tetraethyl ammonium chloride to relieve symptomatically the effects of circulatory insufficiency is remarkable. Rest pain from Buerger's disease, claudication pain from Buerger's or arteriosclerosis obliterans, causalgia pain, including the pain and swelling of reflex sympathetic dystrophies and Sudeck's osteoporosis, may be relieved.

The drug has been used in several hypertensive cases with great reduction in systolic and diastolic pressures. Of course, this is only an effect of short duration. We feel, as does Birchall,⁵ that this compound may be of some value in determining the suitability of a case for sympathectomy. In a few cases the drug did not lower the blood pressure (evidently due to humoral effects). However, even in those hypertensive cases where pressure is not lowered, relief of headaches and associated symptoms is usually obtained.

Our favorite case is the restoration in vision that case number five obtained from the daily injections of tetraethyl ammonium. This means more when it is considered that two ophthalmologists told her that her eyesight was lost.

It must be remembered that the patient must remain recumbent for at least 30 minutes after intra-

venous injection of the drug even though the blood pressure has reached its former level.

We feel that this drug has a variety of uses:

1. It is beneficial in breaking up the reflex arc in causalgic states and reflex sympathetic dystrophy.
2. It is the best adjunct to the cessation of the use of tobacco in the treatment of Buerger's disease that we have used.
3. It is our belief that it is the essential factor in saving the eye in case number five.
4. It definitely relieved claudication pain and weakness in cases of arteriosclerosis, chronic obliterans.
5. In our opinion it was an important factor in the saving of the limb in case number six.
6. We feel it is an aid in selecting suitable hypertensive cases for sympathectomy.
7. In those cases that taste the drug, we feel it is worth-while to note the circulation time, particularly, if they have any cardiac abnormality.
8. We have found it useful to substitute this drug for lumbar paravertebral sympathetic block in mild cases of thrombophlebitis.

SUMMARY

Seven full case reports are given in which tetraethyl ammonium chloride was used. The pharmacology of the drug is reviewed. Its clinical effect and action upon patients is described completely in a general way, as well as its effect upon individual cases. In addition to the case reports, there is mention of the effect of the drug on blood pressure. Pharmacologically it produced an effective but transient block of the autonomic ganglia. When one is aware of its actions and proper precautions are taken it proves to be relatively nontoxic. In many of our cases it was used as an outpatient procedure.

ADDENDUM

Since the material for this paper was completed, in 1947, much more experience has been gained with tetraethyl ammonium.

The purpose of the addendum is to furnish the reader a better method of giving this drug. Credit for the method of administration goes elsewhere. Drs. Ulrich, Kohlstaedt and Pierce* have been giving 20 cc. of tetraethyl ammonium salt in 1,000 cc. of normal saline by continuous intravenous drip at the rate of 80 to 90 drops per minute. An abstract of the original work will be found in *The American Journal of Medicine*, Vol. 6 (May) 1949, p. 664, under the section of "The American Federation of Clinical Research." Doctor Lyons, of Syracuse, has been giving the drug in this manner but has not published any data.

One great advantage in giving the drug in this manner is that the blood pressure does not vary significantly during an infusion; as a result, the pulse pressure is not narrowed nor the cardiac output decreased. The vasodilating effects are more effective and prolonged. The main reactions are ptosis, dilatation of the pupils,

* Lilly Laboratory for Clinical Research, Indianapolis General Hospital.

blurring of vision, extreme dryness of the mucous membranes and drowsiness. There is pronounced flushing of the face and dryness of the skin from vasodilatation. Occasionally a patient chills severely. The author supposes this reaction to be due to excessive heat loss from vasodilatation. The danger of the orthostatic hypotension still exists. An hour and one-half rest after completion of the infusion was insufficient for one patient. After thirty miles of driving from the hospital he felt very light-headed, dizzy and had a heavy, tingling feeling in his legs. He could hardly walk, due to an ataxic gait. Other patients were not so affected after two hours of rest in a supine position.

The amount of dilatation that one obtains is usually greater and more prolonged when this method is used. In one case of Buerger's disease the maximum rise in temperature of the involved area was $5\frac{1}{2}^{\circ}$ and another case $8\frac{1}{2}^{\circ}$. In a relatively young patient suffering with diabetes and arteriosclerosis obliterans, the increase was 4° C. over the affected area and 7° C. change at the corresponding site on the opposite extremity. In an elderly diabetic with gangrene of the distal portion of the right great toe a rise of 5° C. in temperature over the ball of the foot occurred.

More detailed results are to be published later.

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COMPLICATIONS IN TREATMENT OF INCARCERATED HERNIA WITH VASODILATANT DRUG

CASE REPORT

TED L. GRISELL, M.D.

INDIANAPOLIS

MANY methods of treatment have been recommended by surgeons to stimulate the circulatory return to an incarcerated loop of bowel. The oldest probably is that of using warm, moist towels in which the local vasodilant effect of heat is obtained. Lewis,¹ however, has shown that packs of 47 degree C (117.6 F) may cause tissue damage and even thrombosis. Oxygen inhalations have not been shown to effect any increased circulation in an embarrassed vascular system. Herrlin, Glasser and Lange's⁶ suggestion of using mesenteric injections of procaine have been tried and reported elsewhere as having some vasodilating effects. This work was among the first to recognize the physiological effects of strangulation and its vasospastic vascular responses.

Several believe, like Ochsner,² that the arterial spasm is an associated etiological factor in the terminal necrosis in a venous occlusion, such as is seen in strangulated hernia. Lange and Boyd³ reported the use of fluorescein injected intravenously as a test of viability, this test depending on the fluorescein solution (15 cc. of a 5 percent solution given intravenously) being observed under

ultraviolet light to enter the affected loop of bowel. Although this is a test of viability, it has no beneficial effects on the circulation and would have no reliability in preventing the complication seen in this reported case and in others where circulatory return was unquestioned.

Nothing has quite excited the imagination as have the spectacular photographic reports of Laufman and Method,⁴ who experimentally produced controlled strangulation and used papaverine following the release of the bowel to give an immediate vasodilatation to aid in the circulatory recovery of a strangulated loop. It was on the basis of these reports, plus the medical experiences of using papaverine in other vasospastic conditions such as coronary insufficiency and pulmonary embolism, that it was decided to utilize this medication in a clinical case as nearly like the experimental cases of Laufman and Method as possible.

This case is presented not to refute the careful experimental findings outlined above but to indicate the caution with which a surgeon must act in evaluating the viability of embarrassed bowel.

CASE REPORT

The patient was a white female, age 76, with a history of cramping and abdominal pain, nausea and vomiting, of twenty-four hours duration.

Present Illness: Onset of nausea and vomiting eight hours prior to admission and twenty hours after a low abdominal postoperative ventral hernia had become irreducible.

Past History: Pelvic laparotomy 30 years previously was followed by the appearance of a low midline hernia, 8-10 cm. in diameter, two weeks after surgery. This hernia had not increased in size and had always been easily reducible until present illness. Patient also gave a history of having pneumonia 3 times in the past 8 years. No other serious illnesses or operations.

Family History: Irrelevant.

Physical Examination: Temperature 100.2 degrees. Well developed, moderately dehydrated, white female, rational, alert, but vomiting dark green, foul-smelling material.

Head: Eyes reacted to light and accommodation. Some perioral cyanosis.

Chest: Lungs contained few scattered rales. Heart was enlarged in size to percussion. P.M.I. was in the fifth interspace in the anterior axillary line. Rate was regular with no murmurs. Blood pressure was 190/90. Radial arteries revealed grade 2 arteriosclerosis on palpation.

Abdomen: On inspection, an orange-sized mass was observed in midportion of a midline suprapubic incisional scar. This mass was firm, tender, and warm to the touch. Liver was not palpable. Abdomen was not distended. Bowel sounds were present but diminished. Kidneys and spleen were not notably enlarged.

Vaginal examination revealed an atrophic senile vagina. Uterus was not palpable. Cervix was small. Rectal examination revealed no gaseous distention or feces.

Urinalysis was essentially negative. Rbc. 3,780,000; Hb. 12.5; wbc. 12,850; Polys. 88%; Lymphs. 12%.

Extremities were normal. Diagnosis of strangulated postoperative ventral hernia and vascular hypertension was made. Patient was given atropine, 1/150 gr., and operated under sodium pentothol anesthesia.

OPERATION

At operation the hernial sac was found to contain a mass of normal appearing omentum and a single 10 cc. length of almost black small bowel. The hernial opening was enlarged and the embarrassed bowel was exposed. At this time 1 gr. of papaverine was given intravenously and warm laparotomy sponges were applied externally. An immediate vasodilatation was observed and within 20 minutes the bowel was bright red in color. Active peristalsis in the involved loop could be

observed. The bowel was replaced into the abdomen. Further exploration revealed numerous adhesions with a band forming a loop between the anterior abdominal wall and the cervical stump. This was freed and peritonealized. The gallbladder was palpably normal. No further pathology was noted. The hernia was repaired by overlapping of the fascia, using silk sutures.

Postoperatively the patient was given papaverine, ½ gr., intramuscularly every 4 hours for 3 doses, ascorbic acid, 200 mgm., daily, and intravenously 5 percent glucose in normal saline. Liquid diet was well tolerated on first postoperative day. Bowel sounds remained good. Patient was passing gas and no abdominal distention was noted. Soft diet was begun on third postoperative day, which was well tolerated. Enemas produced good to excellent results on the second, fifth and eighth postoperative days.

On the night of the eighth day the patient vomited approximately 1,000 cc. of liquid material. At this time the bowel sounds were excellent. No distention was noted. The wound was clean and the skin sutures were removed. Highest temperature was 101 on the first day, with range between 98.6 and 100, up to the morning of the tenth day. At this time the patient had vomited three times during the night and examination revealed a localized moderate distention of the lower abdomen, with tympany and a point tenderness just to the right of the hernia repair. X-ray of the abdomen revealed two dilated loops of small bowels, typical of mechanical obstruction, but also revealing some gas present in the distal ileum and in the colon, and some free peritoneal fluid. The interpretation was that of an early mechanical obstruction. Clinically the diagnosis appeared to be either a mechanical obstruction due to involvement of the bowel in the adhesions noted at previous surgery, or an obstruction at the site of the strangulated bowel.

The patient was prepared for surgery by aspiration of the stomach by Levin tube and administering 1/150 gr. atropine intravenously.

The operation was performed using dilute solution of sodium pentothal by drip intravenously with curare 20 units as needed. On opening the abdomen a small quantity of free fluid and numerous dilated loops of jejunum were encountered. In the midportion of the small bowel, in the region of the previously strangulated segment of bowel, an area of marked thickening and constriction was found which had obliterated the lumen with fibrosis and edema. This was resected and an end to end anastomosis was done. Pathologically the sections of this segment revealed mural hypertrophy due to fibrous scar tissue and edema.

Postoperatively the patient was given intravenously 5 percent glucose in normal solution, vitamin B complex, ascorbic acid, and 2 U.S.P. units of Digifolin intramuscularly. In spite of these measures the pulse rate mounted to 130 and cyanosis increased. Amino acids and whole blood were given

the first part of the day. At this time bowel sounds were greatly diminished and the blood pressure fell to 110/70. Continuous Levin suction was unable to cope with reverse peristalsis and the patient vomited a small quantity of brownish material, some of which was aspirated. The course was rapidly downhill and death occurred on the second postoperative day.

Autopsy revealed multiple patches of gangrenous bowel evidently due to thrombosis of the small branches of mesenteric arteries. Hypostatic pulmonary congestion was evident.

DISCUSSION

In this case it is the author's opinion that the use of papaverine definitely was beneficial in restoring the circulation to a strangulated loop of intestine. However, in this instance the bowel became secondarily obstructed because of the secondary edema associated with the fibrosis following a long-standing, recurrent incarceration with mucosal sloughing and scarring.

This case represents an entity which should be recognized. Reference is made to case reports listed in the bibliography.^{5 7 8} A lesson learned may be that some additional procedure at the time of the first operation might have been lifesaving. An entero-enterostomy seems to be the safest suggestion, as a resection with the anastomosis of a dilated loop of bowel is notoriously difficult and fraught with danger.

SUMMARY

This case report of a strangulated hernia treated surgically with the use of papaverine intravenously to aid in the circulatory return, is presented to give an example of a possible complication to this treatment, namely, secondary obstruction due to edema and fibrosis in the involved segment of bowel. A possible solution to this problem is proposed by the suggestion of short circuiting entero-enterostomy.

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QUESTIONS WANTED FOR PANEL DISCUSSIONS

Physicians are invited to submit questions on the subjects of "Peripheral Vascular Diseases" and "Hospital Rules and Regulations," which will be discussed by panels on Wednesday afternoon, September 28, and Thursday afternoon, September 29, respectively, during the annual session.

The questions should be mailed to Dr. Ralph U. Leser, chairman of the Committee on Scientific Work, 207 Hume Mansur Building, Indianapolis 4, who will turn them over to the moderators. Receipt of the questions prior to the meeting will enable the panel leaders to present a more interesting program.

MANAGEMENT OF OMPHALOCELE, OR EXOMPHALOS

REPORT OF A CASE

T. D. CARPENTER, M.D.

B. K. ZARING, M.D.

COLUMBUS

A RECENT review of the literature regarding omphalocele has revealed surprisingly little conformity of opinion regarding many pertinent details of management. Furthermore, variously reported mortality rates range from 0 percent to 100 percent. We therefore feel justified in calling attention to what seems to us a logical plan of care, from the time the baby is delivered until surgery and postoperative treatment have been completed. We claim no particular originality for content of this paper, except perhaps in anesthesia, but in no one report did we find all the information that seems necessary for proper management of this condition.

Omphalocele occurs in about one in 5,000 births, is frequently associated with other anomalies, is more common in males, and is said to be associated with prematurity.¹ Although it is well known that umbilical hernia occurs more frequently in negroes than in white people, no reference was found as to the difference in rate of incidence of omphalocele in the same two races.

The term omphalocele, and its synonym exomphalos, should be reserved to describe the protrusion of intra-abdominal contents through the incompletely closed abdominal wall and into the umbilical cord. On the other hand, the term umbilical hernia is understood to designate the condition of protrusion of abdominal contents through a defect in the abdominal wall beneath the closed umbilicus or navel. Thus an omphalocele is to be distinguished from an umbilical hernia by the absence of navel skin in the former and by the presence of a navel in the latter.

CASE REPORT

On January 21, 1948, at 1:10 P.M. a full term, white, male infant, weighing 6 pounds, 3 ounces, was delivered without difficulty by low forceps. The mother was an unmarried primipara whose labor had been normal and uneventful. The baby cried spontaneously and voided urine immediately following delivery. Examination revealed a mass about 2½ inches in diameter, roughly spherical in shape, which protruded through the umbilical opening and into the umbilical cord. The mass seemed to increase in size when the baby cried. No peristaltic waves could be felt, nor could

peristaltic sounds be heard by auscultation. The infant appeared normal otherwise, except for a skin dimple over the sacrum suggestive of pilonidal sinus.

A diagnosis of omphalocele was made, and at 9:15 P.M. on the day of birth the infant was operated upon. The area of the protruding mass and the surrounding abdominal skin were carefully prepared with tincture of merthiolate and the skin and subcutaneous tissue around the mass were infiltrated with 1 percent procaine. An incision was made in a linear direction on the right, extending from the skin edge to the apex of the mass and through the peritoneal hernial sac. The herniating mass was dissected free from the rather firmly adherent peritoneal covering and was identified as the right lobe of liver and gallbladder. The peritoneal sac and remnant of cord with umbilical vein and arteries were completely removed from their attachment to the periumbilical skin. An unsuccessful effort was made to reduce the mass without further incision. Following this, an incision 1½ inches long was made transversely from the umbilical opening on the right. The herniating liver was then easily reduced. The peri-umbilical skin edge was dissected from its peritoneal fusion or attachment, the skin edges freshened, and the abdominal wall, including peritoneum, rectus sheaths, and rectus muscle, was closed with a continuous suture of chromic 00 catgut. A running suture of chromic 000 was used to close the skin. Throughout the operation the infant's crying, with consequent interference with operative procedure, was successfully controlled by having a nurse hold a moistened gauze square filled with sugar and shaped as a nipple in the infant's mouth. Abdominal relaxation thus obtained was good.

The postoperative care was that of feeding any full term newborn, except that in addition 10 cc. of normal saline, containing 5,000 units of penicillin, were given subcutaneously every three hours for three days. The birth weight was regained on the fourth day after a loss of only five ounces. On examination on February 14, 1948, which was the twenty-fourth day after birth, the weight was seven pounds, six ounces, and the wound was completely healed with no evidence of ventral hernia. Examination on March 6, 1948, revealed a left

inguinal incomplete hernia which was first noticed by the mother five days earlier.

COMMENT

Omphalocele is one of those rarely encountered entities that the accoucheur must instantly recognize. It seems quite conceivable that in the event of a small herniating mass, containing perhaps a single loop of intestine, one could easily mistake it for a large but otherwise normal cord and very disastrously cut and ligate it.

Early surgery is imperative. Whether one extends the umbilical opening linearly or transversely depends upon personal preference for midline or transverse incisions. Presence of the liver in the herniating mass is believed to give an unfavorable outlook, due to the fact that the abdomen is not developed sufficiently to accommodate it when reduced to that cavity. In a series of cases reviewed by Gross and Blodgett,² out of eight cases in which a part of the liver was in the sac there were six deaths. In this same paper the authors advocate avoiding the production of an intra-abdominal increase in pressure which in turn causes respiratory and circulatory embarrassment, by sacrificing a strong abdominal wall closure, if necessary, even to the extent of closing only skin and subcutaneous fat, if this is all that can be done without tension. The abdominal wall defect thus left can be repaired at a subsequent date. This seems to be a procedure of considerable merit. On the other hand, Oberholzer,³ recommends that the liver, if involved, should be reintegrated only partially and the remainder sutured to the margin of the peritoneum and either resected immediately or ligated off and allowed to separate by aseptic necrosis. This would appear likely to give a less desirable result, in that greater surgical shock could be anticipated, considerable liver oozing and bleeding would surely occur, and the abdominal wall defect would be fully

as extensive as that produced by the above-mentioned alternative method. In addition, there is, of course, the actual loss of liver substance.

Frequent reference is made in the literature to removing the appendix at the time of operation. Since the mortality figures are none too satisfactory in these infants, the wisdom of any such added surgical procedure as a routine is to be questioned. It is true that the most common herniating viscus is that of the midgut, which includes the appendix, and it is quite conceivable that the appendix could be materially damaged, in which case it should be removed. Unless this be the case, we believe the appendix should be allowed to remain undisturbed.

Both ether and chloroform as general anesthetic agents, and procaine as an infiltration agent have been used. Some writers report the use of no anesthesia for this operation. We found no reference to use of the sugar nipple, which in our case was highly satisfactory. Further trial with this method of obtaining abdominal relaxation for surgery of the newborn is recommended.

Tight binders and dressings probably interfere with digestion and respiration and should be avoided unless the type of abdominal wall closure is considered unsatisfactory, as when all layers cannot be utilized.

SUMMARY AND CONCLUSIONS

Discussion of the management of omphalocele is given as it pertains to the obstetrician and to the surgeon. Included is the report of a case successfully treated.

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NEXT MONTH!

MEDICAL YEAR BOOK ISSUE

The July issue of *THE JOURNAL* will be the annual Medical Year Book issue. It will contain the names of members of the Indiana State Medical Association and the Woman's Auxiliary to the Association, as well as other useful information of a non-scientific nature. Extra copies of the roster will be available.

The Medical Year Book Number has been the January issue heretofore. Watch for this special issue! You will want to keep it on your desk for future reference.

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

LICENSURE OF FOREIGN MEDICAL GRADUATES

EVENTS prior to and during the recent World War deranged the system of medical education in Europe to a serious degree. Educational standards in some foreign medical schools have been lowered until it is impossible for them to graduate adequately educated doctors.

Because some of the foreign medical graduates, both American and foreign born, are planning to seek certification for practice in the United States, the problem of securing information about foreign medical schools is a most important one.

The American Medical Association, through its Council on Medical Education and Hospitals, is sponsoring an unofficial body known as The Committee on Foreign Medical Credentials, for this purpose.

Licensing boards in this country usually judge their candidates partly by examination, and partly by evaluating the standards of the school from which they graduate. The fallacy of admitting physicians to practice solely on the basis of examination, and without any consideration of the quality of preparation, is widely recognized.

Periodic surveys of American and Canadian medical schools are accomplished by the A.M.A. and by the Association of American Medical Colleges. The extent by which this procedure has raised the quality of medical education is not generally appreciated. The present high standards in the United States are due in a large part to this self-imposed system.

American medical licensing bodies have depended on the findings of these surveys in admitting candidates to their examinations. They have been able to certify as adequately prepared those who successfully passed the examinations because the undergraduate education has been on a high level.

In order properly to assess the qualifications of candidates with a foreign education it will be necessary to have information regarding the standards of the European schools. It is not only important to exclude foreign graduates who are ill-prepared, but it is also important that we admit to practice those who are well educated and who wish to practice in this country.

The task is admittedly a difficult one. It will be

difficult to evaluate a foreign school as it is being conducted at present; and even more difficult to judge its educational potential for a period of several years in the past.

It should be possible, however, to determine which foreign schools are maintaining standards comparable to those of American colleges. With this information at hand, licensing boards will be able to examine foreign medical graduates with fairness, and assure adequate protection for the public.

SATURATION POINT

MEDICAL schools in this country have reached the saturation point in student enrollment. With present facilities, any further increases in the number of students would endanger both the quality of instruction and future medical standards. The alternative, of course, is expansion. That, however, involves acceptance by the public of big outlays of funds. And medical schools can't be enlarged overnight; the high degree of technical training required for their staffs, and costly and complicated laboratory equipment require both time and careful planning. Medical school man power already is taxed to the utmost.

An excellent illustration of the overall situation is provided by the Indiana University Medical School. This week the school accepted 150 students for admission in the September class, a notable increase over the 128 students normally admitted each year. Yet even this oversized group had to be pared down from more than 1,000 applicants. Generally, only one out of three applicants can meet entrance requirements, but even at this ratio it is apparent that more than 150 competent young men could not be enrolled at I. U. because there simply was not enough room.

If Indiana wants more doctors, its citizens must be prepared to provide the necessary facilities. Additional funds for the I. U. medical school were supplied last year by Governor Ralph F. Gates and the State Budget Committee, and continued somewhat reluctantly—with substantial reductions in the budget request—by the recent session of the state legislature. But nowhere nearly enough money is available for the scale of expansion that is necessary if Indiana wants its medical school to train 300 doctors a year.

Consider, for example, the estimates by Dr. Dean F. Smiley, secretary of the Association of American Medical Colleges: "It costs about \$10,000,000 to set up a good teaching hospital for an entering class of 100 students, another \$5,000,000 for the school itself, and a yearly budget of \$500,000. The average medical school tuition is \$513 a year, while the average cost per student to the school is \$2,200."

In addition to these financial headaches, there is a shortage of professors and faculty members and a shortage of laboratory space.

The nation's medical schools already have done

a superb job, turning out enough physicians and surgeons to give this country the highest standard of medical care in the world—besides providing one physician for every 710 persons. That is a better ratio, incidentally, than in any of the countries that boast of the accomplishments of socialized medicine.

If the United States, and Indiana in particular, want more doctors, citizens should be planning now for the funds and physical plant necessary to produce them.

The Indianapolis News, April 1, 1949.

One of the worst mistakes that can be made about medical care is to look upon it as a commodity. It no more lends itself to being a commodity than does religion because it is on the very next shelf to religion in its closeness to the lives of human beings.

Frank H. Lahey, M.D.

TIME TO STAND UP AND BE COUNTED!

There have been a few instances recently in which medical organizations, particularly scientific groups, have indicated reluctance to go on record against Compulsory Health Insurance on the ground of propriety.

The question raised is whether a scientific group should "get mixed up in politics."

The answer to that question is that we *are* "mixed up in politics" whether we like it or not, because medicine has been brought under political attack.

The only question which remains is whether we are going to defend our profession against that political attack—and how we can do it most effectively.

If Compulsory Health Insurance is enacted, every medical organization will be subject to political controls and influence—and every doctor will be restricted in the practice of his profession. Then we really will be "mixed up in politics!"

That issue, we believe, makes it imperative that all medical organizations—scientific or otherwise—take their stand, publicly and vigorously, against the emasculation of sound medical practice.

American medicine needs to present a united front against politically-controlled medical practice—and we believe it is not only ethical, but highly desirable for our scientific groups to make their position known.

Let's stand up and be counted!

*George F. Lull, M.D.,
General Manager,
American Medical Association.*

Editorial Notes

Quoted below are some encouraging fighting words from Robert F. Hurleigh, commentator for WGN and the Mutual Broadcasting System, spoken before the Fifth Clinical Conference, Chicago Medical Society, March 3, 1949, as reported in the Chicago Medical Society Bulletin:

"Let it be noted well that in every plan which has been presented by the collectivists in this country since they sold the administration on the NRA we have had the evilness of the threat of state force. And yet they hide behind the veil of liberalism. But, in every plan there is a desire to take away a personal liberty. And the individual is soon confused into thinking those who would protect his personal liberties are reactionaries while those who would take away these liberties in exchange for a guaranteed security in a brave new world, would make him like it with state force. Therefore, in fighting the good fight to keep your profession from being controlled by the collectivists you are in honorable combat. Your weapons are words. Your shield is your common sense. You have waited too long for the attack which you should have known was coming. You have waited in the forlorn hope that by some curious reasoning it would stop short of your profession. You ignored the warnings. Now you know. And now you know that the attack will be heavy for the weapons of the enemy have been sharpened and improved through years of application and the arsenal seems unlimited. Yours is an honorable profession. You have a right to defend it."

If there be any who have not paid the A.M.A. assessment, we hope these words from a layman will disturb their professional conscience at least a little.

Three-fourths of all the babies born last year will live to the age of 60 and one-half will be alive at the age of 72, even if there is no further improvement in mortality. This is in marked contrast with the beginning of the century when, under the then prevailing mortality conditions, only three-fourths of those born at that time would live to the age of 24 and one-half would be alive at the age of 58.

The number of persons enrolled in Blue Shield plans for prepaid medical care will increase more than 50 percent by the end of 1950.

This is a "conservative" estimate, says *Medical Economics*, national business magazine for physicians, in its April issue. It bases its prediction on "past growth" and "present trends."

The magazine predicts 13 million members in Blue Shield by the end of this year, 16 million by the end of 1950. It cites a 43 percent jump in enrollment to 10,200,000 last year. It points out that growth since the war was 259 percent; since 1942, 1,355 percent.

In terms of purchasing power, the per patient cost of eye care—including professional fee and eyeglasses—is approximately 60 per cent higher in Great Britain under its national health service program than in the United States.

The Pittsburgh Medical Bulletin has a page for which "Questions, facts, clippings, criticisms and suggestions" are "welcomed by the editors." The following appeared in the number for March 12, 1949, and is quoted entirely:

"FOR YOUR INFORMATION"

"The attempt at socialization of medicine, dangerous as it is to the welfare of the people, represents only a phase in the projected socialization of the United States.

"On January 29, 1949, Hon. Roy Woodruff of Michigan quoted an article from the National Economic Council in the House of Representatives:

"We have had occasion more than once to mention the ILO (International Labor Organization). The United States of America joined ILO in 1934, at the instance of Frances Perkins, and ever since that time ILO, directly and through numerous affiliates, has engaged heavily in propagandizing for social insurance, including political medicine. It worked for the Wagner-Murray-Dingell bill. Indeed, it is known that ILO publications furnished much of the material from which the bill was drafted, and there is more than a suspicion that the bill was drawn in collaboration with ILO personnel.

"We pointed out in Letter 200 that a pending convention of ILO, if ratified by the United States Senate, would mean the abdication by the American Government to an international body of all control over relations between American employers and employees. It is this same ILO that seems to be the author and prime mover in the present drive to fasten political medicine on the American people.

"A powerful influence for the adoption of political medicine has come from within the Federal Government itself, notably from the Public Health Service and the Federal Security Agency, whose top directors have an incalculable amount of power to gain if the scheme is adopted. These persons have, in violation of the criminal statutes, been using the money of the taxpayers to influence legislation and enhance their own prestige, power, and emoluments. Conspicuous among these are three officers of the Federal Security Administration: Arthur J. Altmeyer, Commissioner; Isidore S. Falk, Director of the Bureau of Research and Statistics; and Wilbur J. Cohen, Falk's assistant."

"Representative Harness of Indiana has exposed the so-called Physicians Forum, which has been advocating political medicine, under the chairmanship of Dr. Ernest P. Boas, of New York—identified by the House Committee on Un-American Activities as being a member of no less than eight Communist-front organizations."

The article is signed with the initials "W. B. G." Who this is, we cannot guess, but it looks as if he Won't Be Gullible. We wish to thank Hon. Roy Woodruff for airing the above information.



President's Page



GREETINGS CUM LAUDE

IT IS JUNE; graduation time for you of the senior class of the Indiana University School of Medicine and the many other distinguished schools of medicine in these United States.

It is the time when you young men and women who chose as your life's work the noblest of the professions will don your caps and gowns to receive your diplomas.

You careworn survivors of a long, hard struggle, so "lean and pale and leaden eyed" with study, have reached the turn of the road and the coveted goal and most honorable degree.

Doctor of Medicine

Your thrill of accomplishment at graduation time is not yours alone to enjoy.

An enlightened people of a health-conscious nation recognizes the scientific achievements and services of American medicine and enthusiastically welcomes you into practice of your noble profession. They are thrilled with the announcement that this month there will be 5,624 more physicians in the nation and eighty-one more in Indiana. They do not question the quality of American medicine, but they want more of it, and they hope that you will aid in the adequate distribution of medical care by locating and serving where you are most needed.

You have many personal friends and loved ones who share your joy of achievement today; perhaps a dad, a mother, a sister, or a brother, and maybe a young wife or bride-to-be.

Regardless of your moments of apathy or discouragement, they always knew "you would make it," and that this triumphal day would come. Their blood tingled the same as yours, and there was a lump in their throats and mist in their eyes during that solemn moment when they heard you repeat:

"I swear by Apollo the Physician . . ."

It was the Oath of Hippocrates, the oath that all true disciples of Aesculapius have sworn to since the year 357 B.C.; the oath and principles of medical practice that have stood the test of time for two thousand years and more; the oath that distinguishes you as a member of a noble profession that is dedicated to the care of humanity and not to a business or a trade.

If you have the proud heritage of being the son of a physician it is the same oath of your father, be he eminent specialist or beloved country doctor; it makes no difference. It is in his footsteps you proudly follow.

There was impressive silence and solemnity as you proceeded through the declaration of humanitarian and ethical principles of medical practice of the Hippocratic Oath. As you concluded there were expressions of adoration on the faces of all who heard you say:

"While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art respected by all men in all times. But should I trespass and violate this Oath may the reverse be my lot." Amen.

Graduation was over, you were showered with congratulations, and the chapel bells rang out:

"A Doctor is born!"

Only your dad understood the true significance of the words you spoke. He knows that graduation in scientific medicine is just a commencement, a turn in the road, and the beginning of a lifetime of study of man, the unknown.

He knows that to be a good doctor you must practice with your heart as well as your head, know thyself, and have a profound and sympathetic understanding of humanity.

As he shook your hand, he uttered a silent prayer that the Oath of Hippocrates would endure forever and always be the guiding light to the men of medicine, unamended by Congress and unhampered by governmental compulsion.

To you who have met the high standards of medical education, survived and conquered, and who stand on the threshold of a new century in Indiana medicine,

GREETINGS CUM LAUDE, GRADUATE M.D.'s, 1949

Augustus D. Hauss

JAMES WAGGENER JOINS ASSOCIATION STAFF

JAMES A. WAGGENER of Franklin, public relations director of the Indiana Blue Cross-Blue Shield Plans for the past two years, assumed the position of field secretary of the Indiana State Medical Association on May 15. Mr. Waggener succeeded Larry Richardson who continued with the association on a part-time basis as a speaker against political medicine.

Mr. Waggener is devoting most of his time to organizing the campaign against compulsory sickness insurance in Indiana. He serves also as secretary of the Committee on Publicity, Committee on Rural Health and Committee on Medical Education and Hospitals.

Born in Franklin thirty-nine years ago, Mr.



Waggener spent twenty-two years in newspaper work as a business and advertising manager. Before joining the Blue Cross-Blue Shield organization in 1947, he was with *The Franklin Evening Star* in that capacity for sixteen years.

During the recent war Mr. Waggener directed the Johnson County Civilian Defense and won a citation from the Fifth Army Service Command for heading the best civilian defense organization in that area. He was chairman of a committee which raised \$500,000 to finance a county hospital at Franklin and was secretary of the hospital board of trustees for four years.

Mr. Waggener's activities last year included the chairmanship of the Council on Public Education, Indiana Hospital Association, and the secretaryship of the Indiana Nurse Recruitment Committee.

He is a member of the Presbyterian Church, Masonic Order, Rotary Club, National Press Club, Washington, D. C., and the Indianapolis Press Club. Mr. and Mrs. Waggener are the parents of two daughters, aged 8 and 10.

REVIEW OF ONE HUNDRED YEARS OF INDIANA MEDICINE BEGINS IN THIS ISSUE

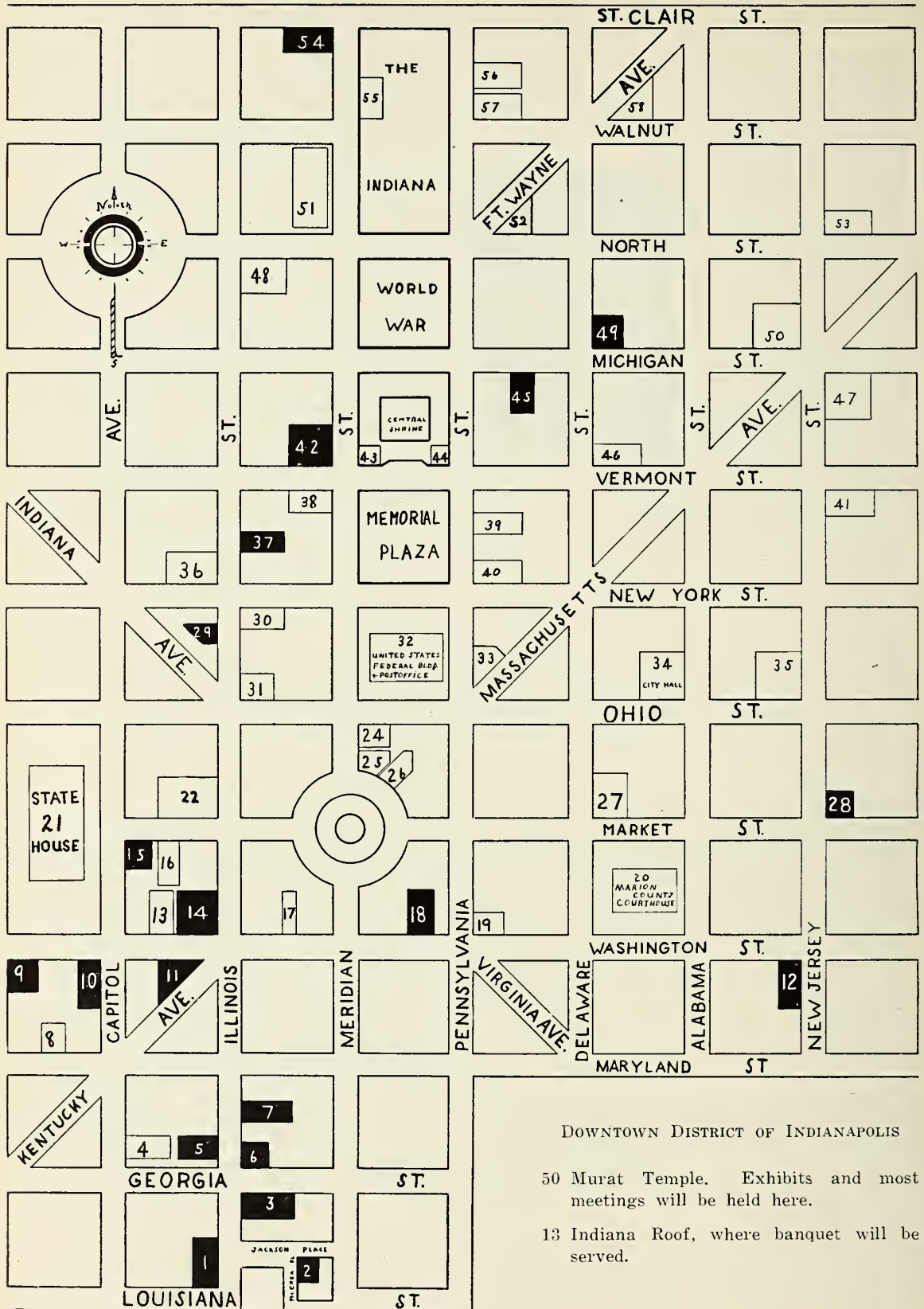
AS A FEATURE of the centennial anniversary of the Indiana State Medical Association, THE JOURNAL is privileged to publish in four installments, beginning in this issue, a review of medical advancement and progress in Indiana for the past hundred years. The manuscript was prepared under direction of the Committee on Centennial Celebration and History, of which Dr. Charles N. Combs of Terre Haute, and Dr. Edgar F. Kiser of Indianapolis, were chairman and vice-chairman, respectively.

More than four years were spent in collecting data and writing the chapters. The plan originally was to publish the material in book form, under the title, *One Hundred Years of Indiana Medicine*, but not enough orders were received to make publication of the book practical from the stand-

point of cost. The Council decided the manuscript was of such great historical value that it should be published. So that every member of the association would have opportunity to read it, the Council voted to print it in serial form, in the June, July, August and September issues of THE JOURNAL. Pictures of all presidents of the state association and other photos will be included.

Mrs. Dorothy Russo of Indianapolis, historical writer, has assisted the committee in gathering and editing the material.

While each installment is on the press, 750 additional copies will be run on book paper and, after the last installment has appeared, will be bound and delivered to those who have ordered books. A few hundred extra copies will be available at \$4.00 per copy.

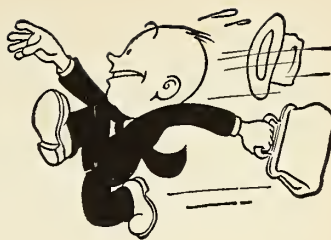


Headin' For Indianapolis!

September 26-27-28 and 29, 1949

Centennial Session

Indiana State Medical Association



... TIME TO MAKE YOUR HOTEL RESERVATION ...

Hotels	Rates
(Numbers Indicate Locations. See Map on Opposite Page)	
54 Antlers	\$3.75- \$8.50
2 Barnes	\$2.00- \$6.00
49 Barton	\$2.25- \$7.00
14 Claypool	\$4.00- \$10.00
* Graylynn	\$4.00- \$6.00
15 Harrison	\$3.25- \$8.75
11 Lincoln	\$3.50- \$10.00
37 Linden	\$2.00- \$6.00
* Marott	\$4.50- \$10.00
* Pennsylvania	\$2.75- \$5.00
* Riley	\$2.25- \$6.00
3 Severin	\$3.50- \$10.00
* Sheffield	\$3.50- \$7.00
1 Spencer	\$2.50- \$6.00
42 Spink Arms	\$3.00- \$12.00
17 Stratford	\$2.00- \$6.00
7 Warren	\$3.50- \$8.50
18 Washington	\$3.25- \$8.50

FOUR BIG DAYS AND NIGHTS

Monday, September 26—Stag party for men. Party for women.

Tuesday, September 27—Musical program. National speaker.

Wednesday, September 28—National speaker on semi-scientific subject.

Thursday, September 29—Annual dinner, followed by dancing to name band.

Scientific Lectures and Television
Every Day

Hotels	Rates
9 Williams	\$2.25- \$6.00
29 York	\$2.00- \$5.00

* Not shown on map.

Committee on Housing:

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Clip and Mail this coupon to hotel

Manager Hotel, Indianapolis, Indiana

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, September 26, 27, 28 and 29, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price:.....
☐ Twin Bed Room with bath ☐ Suite

Arrival date A. M. P. M.

Departure date A. M. P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

PREPAYMENT MEDICAL CARE*

THE rapid and orderly growth of voluntary prepayment medical and hospital care plans has been one of the striking and stimulating economic developments supported by American medicine during the past fifteen years. The initiating and propelling force of these plans was the medical profession acting through its local and state societies and later its national organization. This movement has attained national proportions. At the present time over 30,000,000 people are covered by Blue Cross type hospital insurance and over 10,000,000 by Blue Shield type medical care insurance. This stimulus and the accumulated experience gained by these organizations have prompted many private insurance companies to enter this field, and they are making substantial contributions toward the accomplishment of our ultimate objective, namely—voluntary health insurance at a nominal cost for all the people in the United States. The total number of persons covered by all voluntary agencies is 55,000,000 for hospitalization and 37,000,000 for surgical or medical care.

The American Medical Association is not engaged in the insurance business and has no intention of giving a preferential standing to any one type of voluntary plan. The American Medical Association does believe, however, that it has a definite function to perform, that of evaluating any insurance plan presented to the people, thus protecting them as far as possible against unscrupulous or unsound plans. The American Medical Association further believes that the people should be free to purchase the type of health security they desire. To this end the Council on Medical Service has for the past four years critically examined various plans and has given its approval to numerous plans operating on a local or state basis. The Council has felt

the need for a national organization which would act as a trade and coordinating agency for all medically sponsored plans.

We therefore recommend:

- (1) The formation of a national coordinating agency representing all qualified voluntary prepayment plans in accordance with the proposal made to the Board of Trustees by the Council on Medical Service, February 10, 1949.
- (2) That there shall be no official connection between the American Medical Association and the Associated Medical Care Plans. However, the American Medical Association will continue to approve or disapprove all voluntary medical care plans.
- (3) The recognition of AMCP as a trade organization of member plans and Blue Cross as occupying a similar position for voluntary prepayment hospital care plans.
- (4) The recognition of the responsibility of the American Medical Association to
 - (a) Promote the principle of voluntary insurance by educating the people as to their need for such coverage and by obtaining full cooperation from state and county medical organizations in the local field.
 - (b) Inform the American people of the availability of approved plans that propose to supply on a prepayment basis security against the economic hazards of serious illness.

* Report of the Council on Medical Service of The American Medical Association, April 15, 1949.

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POSEY COUNTY

RUSH COUNTY

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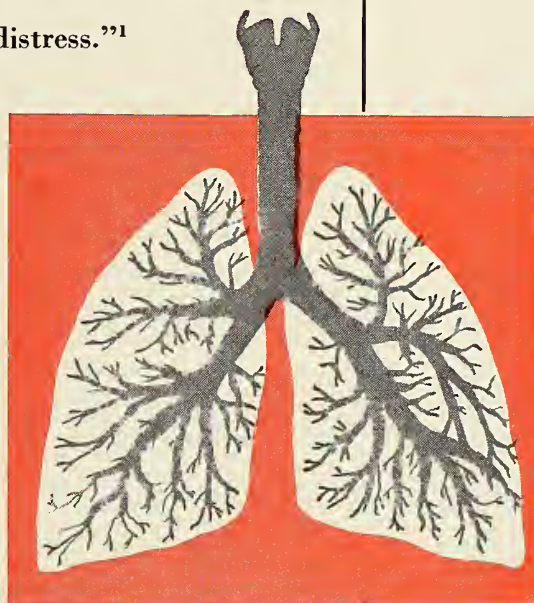
WELLS COUNTY

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In paroxysmal dyspnea, bronchial asthma, selected cardiac cases and Cheyne-Stokes respiration,

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acts by relaxing the bronchial musculature, encouraging resumption of a more normal type of respiration and reducing the load placed upon the heart.

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**Searle Aminophyllin contains at least 80% of anhydrous theophylline.*

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Murphy, F. D.: Treatment of Cardio-vascular Emergencies in the Home. Wisconsin M. J. 42:769 (Aug.) 1943

Medical Panorama by the ASSOCIATE EDITOR

The Monthly Bulletin of the Indiana State Board of Health contains material of much interest to the physician and should be widely read. Some time ago, on this page, we printed some material on the nursing situation from another state. Now we have some more on that subject from Eugenia K. Spalding, R.N., Director, Division of Nursing Education, Indiana University, writing in *The Monthly Bulletin* for February, 1949. She conducted a poll among "physicians, hospital administrators, public health personnel, nurse and other educators, graduate nurses, nursing students and others, young and old," and came up with the following ideas which we have selected from the many presented in her article:

"Several asked, how can we get at once or as soon as possible more qualified nursing personnel (professional and auxiliary) to care for patients in all nursing services: hospital, other institutions, public health agencies and in the home.

"Head nurses complain that they cannot teach nursing students the whole care of the patient any longer because of the use of the functional assignment where many different persons carry on unrelated nursing activities and all nursing activities are not performed by nurses or nursing students. Nursing students, therefore, never see total nursing care and when they become head nurses they have difficulty in directing activities so as to provide total nursing care for patients.

* * * * *

"A physician who is in a position to observe nursing activities in the home, the hospital and the public health agency said: 'We have been and are accustomed to looking to the educational centers and to national and state nursing organizations to hand down to us ready-made answers on our problems—but hasn't the time long been past where you in nursing and those in other health professions need to both *study and apply* what we are learning right at the center of production—that is, *where we treat* the patient or potential patient. We do not need to be the so-called leaders to make such application. As a matter of fact, it rather annoys me to hear people talk about what Washington or New York tells us to do. Let us, of course, not close our ears to what we hear from Washington and New York or any other place but let us make our analyses and applications.'"

Among other recommendations from nursing students themselves were these:

"It is increasingly important for us to know the patient as a person in his own environment and treat him as such.

"Get more adequately prepared instructional and teaching personnel.

"Attract a better type of nursing students into schools.

"Do not isolate us from the community and normal living."

"Set up joint committees of doctors and nurses for continuous study of nursing procedures so as to get the right combination of art and science in nursing."

"We need to determine a revised plan for the preparation of nurses, practitioners (professional and auxiliary) for patient care and in the specialized fields of teaching, administration and consultation."

It will be noticed that in two places reference is made to "auxiliary" personnel in addition to (or perhaps as distinct from) "professional" personnel. This distinction is not further clarified, but it certainly must include the nurse's aide and the practical nurse.

That the nurses themselves are thinking along these lines is shown by the following excerpts from the report of a conference on the Brown Report held at Indiana University in January:

"II. Recommendations on Nursing Education

"A. Secure prompt consideration by officers of administration of accredited colleges and universities for the establishment of 4-year degree curricula for basic nursing education which could be followed by graduate nursing education of university calibre.

"B. Initiate immediately curricula for the preparation of the practical nurse.

"C. Continue and improve the present 3-year hospital curriculum."

The same reaction is observed on the part of the hospital, as witness the following extract from "The Hospital Administrator's Appraisal of Current Nursing Problems," by Owen B. Stubben in *The Rocky Mountain Medical Journal* for March, 1949:

"Before giving my appraisal of current nursing problems, it may be interesting to note briefly what the nurses and other administrators feel the nursing problems of Colorado are, according to the published results of the Governor's Conference on the Nursing Problems in Colorado, as of February, 1948. The Conference

"(A) Emphasized the need for recruitment of and teaching facilities for home nursing personnel.

"(B) Emphasized the need for standardized curriculum in nursing schools.

"(C) Recommended that plans be implemented for the training of practical nurses and for their licensure.

"(D) Stressed the need for continuing recruitment efforts coupled with counseling and vocational guidance programs in secondary schools.

"(E) Placed particular emphasis on the fact that economic conditions must be corrected if youth is to be attracted to the nursing profession and graduates are to be retained in it.

"(F) Finally felt there was a need for increased education of the public to make economical and appropriate use of nursing personnel as related to group nursing in hospitals, acceptance of practical nurse services, development of the home nursing service, and further utilization of the public health nurse.

"It is evident that the various nursing groups feel there is a need for coordinated planning and action on their part in trying to accomplish a solution to the nursing problems which I have mentioned. Obviously many of these problems, if not all of them, are hospital problems even though we as hospital administrators may feel that minimal participation is required of us in the solution of some of them.

* * * * *

"Despite our proclivity for feeling that our individual problems are different from those of our colleagues, it seems evident to me that we have here a remarkable

"a summation of activity"

Council on Pharmacy and Chemistry, A.M.A.

J.A.M.A. 137:789 (June 26) 1948.

In Tincture Mercresin,* secondary amyltricrosols and orthohydroxyphenylmercuric chloride "supplement each other so that the mixture is approximately twice as germicidal for *Staphylococcus aureus* as the component cresol derivatives alone and seven to ten times as germicidal as the mercury compound alone."



Mercresin combines this germicidal potency with bacteriostatic and fungicidal properties for

1. antiseptics of superficial wounds or infections,
2. irrigation of certain body cavities and deep infected wounds,
3. topical application to mucous membranes, and
4. prophylactic surgical preparation of intact skin.

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Acetone 10%
Alcohol 50%

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instance where we are actually all faced with the same problems. I deem it absolutely necessary that we as hospital administrators must unite our efforts and develop as fast a pace as we can in promoting and extending our inter-hospital relationships."

Note the similarity in recommendations arrived at by the two conferences, one in Indiana, the other in Colorado. Note also the inclusion by the Colorado group of the licensure of practical nurses.

Indiana has now advanced from theory to practice through the enactment by the last General Assembly of the Indiana State Board of Nurses' Registration and Nursing Education Act, which

provides for the Licensed Practical Nurse in addition to the Registered Nurse. These titles are the legal titles, the abbreviations for which are "L.P.N." and "R.N." The Act further states: "Sec. 22. Any institution which desires to conduct a school for the training of practical nurses shall apply to the board and submit evidence that it is prepared to give a twelve month program which shall meet the standards prescribed by this act and by the board for the training of practical nurses."

It is to be hoped that the new board will not delay its prescription of standards, so that the role of "L.P.N." can be tried and evaluated.

News Notes

At a meeting of the American College of Allergists on April 17, at the Palmer House in Chicago, Dr. Bennett Kraft, of Indianapolis, read a paper on "The Application of Psychodynamic Concepts in an Allergy Practice."

Dr. C. H. McCaskey, of Indianapolis, was a speaker on the program of the Tenth District Medical Society at Asheville, North Carolina, on April 30. He spoke on "Surgery of the Larynx."

Dr. Richard H. Shafer has announced the opening of an office for the private practice of medicine in Alexandria. He has been associated with the Alexandria Clinic since his separation from military service in September 1947.

Dr. Warren S. Tucker, of Indianapolis, was elected president of the Marion County Tuberculosis Association at its annual meeting on April 25.

Dr. William N. Wishard, Jr., of Indianapolis, was recently reappointed to the State Board of Medical Registration and Examination.

Dr. Lloyd Terry, who has been a staff physician at Billings Hospital in Indianapolis since his release from service, has established an office for the private practice of medicine in Danville, where he is associated with Dr. M. E. Frantz. A 1945 graduate of Indiana University School of Medicine, Doctor Terry served an internship at Memorial Hospital in South Bend, before enlisting in the Navy. He served at Great Lakes, at the Veterans Hospital in Lexington, Kentucky, and at Samson Naval Base, New York, prior to becoming a member of the Billings Hospital staff.

The Executive Board of the American Public Health Association announces that the 77th Annual Meeting of the Association and meetings of related organizations will take place in New York City, October 24-28. The Hotels Statler and New Yorker are joint headquarters.

"In Tribute to the American Doctor" is beautifully portrayed on pages 496 and 497 of this issue. You are invited to send for a copy suitable for framing. Display it in your reception room—your patients will enjoy reading it.

The first meeting of the newly formed International Academy of Proctology will be held at the Marlborough-Blenheim in Atlantic City, on Friday, June 10, 1949. The scientific portion of the program will consist of the presentation of papers and motion picture films of interest to all physicians as well as to those specializing in proctology. Further information and a copy of the program may be obtained by writing to Dr. Alfred J. Cantor, International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

POSTGRADUATE COURSE IN UROLOGY

The first Postgraduate Course in Urology to be sponsored by the North Central Section of the American Urological Association will be held at the Hotel Sherman, Chicago, December 5-9, inclusive, 1949. All members of the North Central Section are invited to attend. In addition, the course will be open to residents in urology and to physicians who are interested in a short postgraduate course in urology. The attendance will of necessity be limited and early reservations are requested. The tuition fee will be \$50.00. The Hotel Sherman has set aside ample accommodations for out-of-town urologists. There is a garage in this hotel. Address applications and requests for information to Dr. William J. Baker, 7 W. Madison Street, Chicago 2, Illinois.



The magic wall

Nowhere in the realm of biology exists so highly specialized and so biologically efficient a membrane as the mucosa of the human intestinal tract. Within this mucous membrane, about five millimeters thick, there take place the most intricate biochemical reactions designed to facilitate absorption of the products of digestion.

Research upon the fundamental aspects of hemopoiesis has gone forward steadily at *Lederle* for more than 20 years. Liver extract,

FOLVITE* Folic Acid, vitamins, combinations with ferrous iron, and such products of nutritional value in tissue repair as amino acids, have been made available as rapidly as they could be perfected.

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Certificates are now ready for mailing to former medical officers who served during the war with the designation as Flight Surgeons. The certificates, which are suitable for framing, indicate that the officer concerned was graduated from the Aviation Medical Examiner's Course given at the U. S. Air Force School of Aviation Medicine, Randolph Air Force Base, Texas. Those who are eligible to receive the certificates may secure them by writing direct to The Air Surgeon, Headquarters, U. S. Air Force, Washington 25, D. C. Officers now on active duty are not eligible to receive the certificates.

Change in Regulations
of the

American Board of Orthopaedic Surgery, Inc.

(2) EXAMINATION, Part I.

(a) Eligibility for Examination, Part I: Beginning in the year 1952 the minimum requirements for eligibility for examination, Part I, shall consist of completion of an internship; a year of resident training in general surgery and two years of resident training in orthopaedic surgery on an approved service.

Applicants filing in 1951 for examination, Part I, to be given in 1952 are subject to these minimum requirements.

PSYCHIATRIC AIDE OF THE YEAR AWARD

For successfully eliminating restraint practices in the care of the mentally ill patients in his care, and in recognition of the outstanding devotion and service shown in the discharge of his duties, Roland J. Brand, an attendant at the Milwaukee County Asylum, Milwaukee, Wisconsin, has been named as recipient of the "Psychiatric Aide of the Year Award" for 1948. Announcement of the Award was made by Richard Hunter, executive secretary of the National Mental Health Foundation on behalf of the foundation and the Catherwood-Kirkbride Fund for Research in Psychiatry, joint sponsors of the award.

Every mental hospital in the country, both public and private, was given an opportunity to nominate the attendant or psychiatric aide on its staff who had turned in the most meritorious performance during 1948. In all, more than 15,000 eligible candidates were considered by hospitals throughout the country before the final selections were made by a board of judges, prominent in the field of mental health.

For his achievement in removing restraints from 32 male patients on the most disturbed ward at the Milwaukee institution, overnight, and in completely banishing the continued practice of restraints on his ward and thereby setting an example for the rest of his fellow employees, Roland Brand, as winner of the award will receive a cash prize of \$500 and a citation.

The Chicago Medical Society is offering two postgraduate courses in October, 1949, each of one week duration, which will be open to all physicians who are members of their local medical societies.

A course in Cardio-renal and Peripheral Vascular Diseases will be given October 17 to 22, and a course in Obstetrics, Endocrine-gynecology and Sterility will be offered the following week, October 24 to 29, 1949.

The courses will be given at Thorne Hall on Northwestern University Medical School campus. The faculty for each course will be made up of leading teachers from all sections of the United States and Canada. There will be lectures, question periods, round tables, and short intermissions in the morning and afternoon.

Each course is limited to one hundred.

Additional information may be had by writing Dr. Willard O. Thompson, Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2.

NORWAYS FOUNDATION, INC.

Norways Sanatorium, Indianapolis, the oldest private psychiatric hospital in the state, has just announced that all facilities and equipment are being turned over, without cost, to a new charitable organization, known as Norways Foundation, Inc.

Norways Sanatorium was established in 1898 by Dr. Albert E. Sterne, the first professor of neurology at Indiana University School of Medicine. Since 1943 it has operated as a non-profit institution. The new foundation was created in order to expand legally the charitable and educational activities of the corporation, to provide increased facilities for the care of patients, and to enlarge its capacity for the psychiatric training of doctors, nurses, and social workers, as well as for research. In this way it is hoped to give to Indiana private psychiatric facilities second to none in the country.

Norways Foundation was formed by seven incorporators: Harry Reid, Edward F. Gallahue, Fred S. Boone, Mrs. Genevieve P. Reed, John K. Ruckelshaus, Philip B. Reed, M.D., and Earl W. Mericle, M.D. Recent additions to the board are Mrs. Katherine Atkins and Clarence Efroymsen, Ph.D.

The operation of the hospital, under the Norways Foundation, will continue as it has in the past. All of the Indianapolis physicians in private practice who are certified in psychiatry have served as consultants at Norways in the past year. Persons seeking treatment are referred by and continue in the charge of their family physician.

It is hoped that Norways Foundation, which is so constituted by its articles of incorporation that no profit can ever accrue, either directly or indirectly, to any individual or group of individuals, will serve by making available to a larger number of people the advances in medicine in diagnosis and treatment of emotional and mental illness.

A safe way of treating tinea pedis...

Use Sopronol, hundreds and hundreds of case histories suggest.

Sopronol is physiologic. It utilizes the fatty acids found in human sweat (propionates and caprylates) to combat fungi just as nature does.

And because of this, Sopronol heals effectively and safely. Is virtually non-irritating, non-sensitizing, non-keratolytic.

Fight fungi physiologically... with Sopronol.

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Sodium propionate	12.3%
Propionic acid	2.7%
Sodium caprylate	10.0%
Zinc caprylate	5.0%
Diocetyl sodium sulfosuccinate	0.1%
Inert ingredients including n-Propyl Alcohol	69.9%
	10.0%
	1 oz. tubes

powder

Calcium propionate	15.0%
Zinc propionate	5.0%
Zinc caprylate	5.0%
Inert ingredients	75.0%
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Sodium propionate	12.3%
Propionic acid	2.7%
Sodium caprylate	10.0%
Diocetyl sodium sulfosuccinate	0.1%
Inert ingredients including n-Propyl Alcohol	74.9%
	12.5%
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RECOMMEND PROGRAM TO AID FOREIGN TRAINED PHYSICIANS

The Committee on Foreign Medical Credentials, an unofficial group sponsored by the American Medical Association Council on Medical Education and Hospitals, has recommended that the various agencies concerned with problems of foreign trained doctors who seek to practice in the United States should devise a method for securing information about foreign medical schools at the earliest possible date.

The recommendation was contained in a report of the committee which appears in the April 16 *Journal of the American Medical Association*.

Membership of the committee includes individuals from the Advisory Board for Medical Specialties, the Association of American Medical Colleges, the A.M.A. Council on Medical Education and Hospitals, the Department of State, the Federation of State Medical Boards of the United States, the National Board of Medical Examiners, the Institute of Inter-American Affairs, the Institute of International Education, the World Health Organization, the World Medical Association, and other organizations.

When reliable information about foreign medical schools is obtained, it should be possible for accrediting agencies to prepare a list of foreign medical schools whose graduates may be considered to have received training comparable to that offered by medical schools in this country, an editorial in the same issue of the *Journal* commented, adding:

"It would then seem reasonable that the state boards and the National Board of Medical Examiners admit graduates of these schools to examination, provided they can demonstrate sufficient familiarity with recent scientific advances, with the practices and customs of American medicine, and with the English language."

Leaders in State Selected to Serve on Committee to Consider Ways for Improvement of Indiana Nursing Service and Its System of Nursing Education

A workshop on the question "What Should Indiana Plan in Relation to Recommendations on Nursing for the Future," a report of a study completed by Dr. Lucile Brown, of the Russell Sage Foundation, last year, was held on the campus of Indiana University under the auspices of the Indiana State League of Nursing Education and the Division of Nursing Education, Indiana University, in cooperation with the Indiana State Board of Examination and Registration for Nurses, the Indiana State Board of Health, and the Indiana State Nurses' Association, on January 5-6-7, 1949.

During this workshop, certain recommendations concerning nursing service and nursing education in the state of Indiana were made.

To implement these recommendations, Mrs. Eugenia K. Spalding, director of the Division of Nursing Education of Indiana University, was appointed to select a small committee which would

select a state-wide committee composed of persons representing the groups attending the workshop, nursing, medicine, other health fields, education, and the consumer of nursing service. This small committee included, besides Mrs. Spalding, the following members: Miss Marion F. Roberts, president Indiana State League of Nursing Education; Miss Leona R. Adam, president Indiana State Nurses' Association; and Miss Caroline Hauenstein, educational director, Indiana State Board of Examination and Registration of Nurses.

The following professional leaders and citizens of Indiana have been appointed by this small committee to serve on the state-wide committee to implement the recommendations of the workshop, for developing a proposed plan, securing the needed funds and personnel to do the job.

Dr. J. W. Ashton, dean, College of Arts and Science, Indiana University, Bloomington, will serve as chairman of the committee.

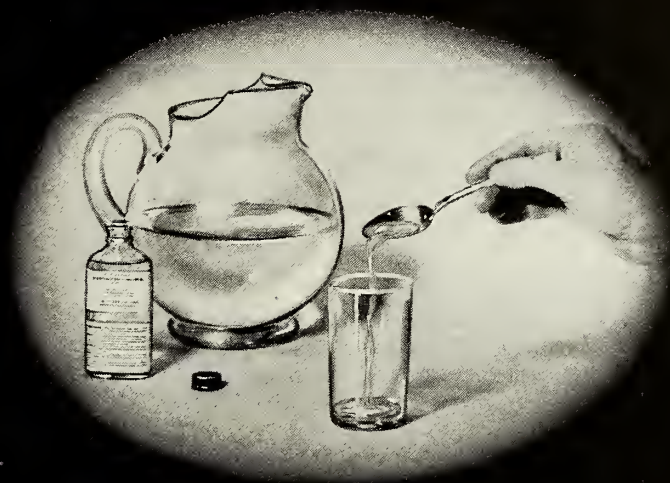
Other members include Mr. Robert E. Neff, administrator, Indianapolis Methodist Hospital; Mrs. Montgomery Lewis, member, Board of Directors, the National Organization for Public Health Nursing, and of the Indianapolis Visiting Nurses Association, Indianapolis; Dr. Augustus P. Hauss, president Indiana State Medical Association, New Albany; Mr. William H. Strain, Admissions Office, Indiana University, Bloomington; Mr. James A. Stewart, Editor Indianapolis Star; Mr. Paul Bergevin, director of community organizations, Division of Adult Education, Indiana University; Mrs. Alice Sanders, health secretary, Council of Social Agencies, Indianapolis; Mr. John Hicks, chief accountant, Indiana University, Bloomington; Sister Delphine, director, School of Nursing and Nursing Service Department, St. Vincent's Hospital, Indianapolis; Miss Margaret I. Boal, director, School of Nursing and Nursing Service, Ball Memorial Hospital, Muncie; Dr. L. E. Burney, commissioner, Indiana State Board of Health; Mrs. Dorothy Buschmann, field executive, Indiana Social Hygiene Association; Miss Mabel McCracken, instructor, St. Mary's Hospital School of Nursing, Evansville; Dr. Ernest Miller, president, Goshen College, Goshen; Dr. Martha O'Malley, director, Division of Hospital and Institutional Services, Indiana State Board of Health; and Miss Caroline Hauenstein, educational director, Indiana State Board of Examination and Registration of Nurses; and Mr. J. Milo Anderson, president, Indiana Hospital Association, Gary.

Mrs. Lewis and Mr. Hicks represent the consumer of nursing service.

Ex-officio members of the committee include Dr. Herman B. Wells, president, Indiana University; Sister Medelewa, president, St. Mary's College, Holy Cross; and Mrs. Eugenia K. Spalding, director of Division of Nursing Education, Indiana University.

The committee will hold its organization meeting soon, and it is expected that within six months at least a tentative program for the nursing profession of Indiana can be published.

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Dr. John W. Courtney, a 1943 graduate of the Indiana University School of Medicine, has opened an office for the practice of internal medicine at 518 Hume Mansur Building, in Indianapolis. An Army veteran with twenty-six months' service, Doctor Courtney recently completed a residency at the Crile General Hospital in Cleveland.

Dr. Robert Kabel, who has recently completed a residency at Indianapolis General Hospital, is now associated in the practice of orthopedics with Dr. Malachi Topping, at 505 Tribune Building, in Terre Haute.

Dr. J. C. Richter has become associated with **Dr. R. B. Jones** in LaPorte. Doctor Richter is a 1941 graduate of Harvard Medical School, and interned for two years at Presbyterian Hospital in Chicago. He is a veteran of World War II, having served for three years with the Army in the European theater. Following the war he was surgical resident at the Presbyterian Hospital for four years and at the Children's Memorial Hospital for six months.

Dr. John H. Sterne, who recently completed a residency at the Indiana University Medical Center, has opened an office for the practice of orthopedics in Evansville. Doctor Sterne is a 1942 graduate of the Indiana University School of Medicine, and spent four years in the Army.

Dr. Victor F. Albright has opened an office for the practice of surgery in New Castle, upon completion of a residency at the Indiana University Medical Center. Doctor Albright served for three years as a flight surgeon with the 323rd Bombardment Group in the European Theater of War.

Announcement has been made of the opening of an office at 2311 N. Meridian Street, in Indianapolis, by **Dr. Paul F. Muller**, who has recently returned to Indianapolis after completing a three and one-half year residency in obstetrics and gynecology at the Lying-In Hospital in New York. A 1940 graduate of the St. Louis University School of Medicine, Doctor Muller spent four years in the Army, being separated from service with the rank of lieutenant-colonel.

A 1941 graduate of Indiana University School of Medicine, **Dr. D. Edmund Storey** has opened an office for the practice of internal medicine at 913 Broad Ripple Avenue, in Indianapolis. He interned at the Indiana University Medical Center before entering the Army, where he served for four years in the ETO, with the 643rd Medical Clearing Company. He was a major at the time of his separation from service. Following his discharge, he served for two years as a resident at Cold Springs Veterans Hospital, in Indianapolis, and for the past ten months has been on the full time staff of Billings VA Hospital.

Dr. Daniel C. Tweedall has opened an office for the practice of dermatology and syphilology at 527 Sycamore Street, in Evansville. He is a 1939 graduate of the St. Louis University School of Medicine, and served an internship at the St. Louis City Hospital, and one year of general residency at Deaconess Hospital in Evansville. Following this, Doctor Tweedall entered into the general practice of medicine in 1941, prior to his entrance into the service, in 1942. He served for four years as a flight surgeon with the Army Air Corps. After his separation from service, he took three years of special training in dermatology and syphilology in St. Louis, including training at the Barnard Free Skin and Cancer Hospital and the Barnes Hospital. At Barnes Hospital he took a preceptorship under Dr. Richard S. Weiss, who is chief of the dermatology department there, and chief of the dermatology department of the Barnard Free Skin and Cancer Hospital.

A 1944 graduate of the Indiana University School of Medicine, **Dr. Paul E. McGuff** has opened an office for the practice of surgery at 605 E. Maple Road, in Indianapolis. Doctor McGuff spent three and one-half years at the Mayo Clinic following his graduation.

The National Committee for Chile is now receiving gifts for the library of the medical school of the University of Chile at its new collection center in the Library of Congress, Room 318, Washington, D. C. The newer materials in the library, including periodicals, books and reference materials, were totally destroyed in the recent fire. Medical periodicals of the last ten years and recent medical books are urgently needed. Your contribution will be appreciated.

AMERICAN COLLEGE OF PHYSICIANS

Indiana will be host to the midwest regional meeting of the American College of Physicians, which will be held at the Claypool Hotel in Indianapolis, on November 19, 1949. Dr. James O. Ritchey, of Indianapolis, is the governor of the host state of Indiana. This meeting is open to all physicians. Further details will be published in later issues of THE JOURNAL.

LOUISVILLE MEDICAL SEMINAR

The University of Louisville School of Medicine has organized a short refresher program for all physicians in Kentucky and surrounding states. Registration fee for those attending, except for medical students, interns, and hospital residents, will be \$5.00. For further information concerning this seminar, address: Dr. Herbert L. Clay, Jr., Postgraduate Refresher Training, University of Louisville School of Medicine, 323 East Chestnut Street, Louisville 2, Kentucky.

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Dr. Charles F. Deppe, who has been practicing in Edinburg for the past two years, following his discharge from the U. S. Navy, has announced that he has opened an office for the practice of medicine in Franklin.

The Class of 1909 of the Indiana University School of Medicine will celebrate its fortieth anniversary during the centennial convention of the Indiana State Medical Association in Indianapolis, September 26 through 29, 1949. The reunion will be held at 6:00 p.m., Wednesday, September 28, in the Athenaeum.

Dr. Joseph B. Davis, of Marion, has resumed active practice in association with his father, Dr. Merrill S. Davis, and is limiting his practice to surgery. A graduate of Indiana University School of Medicine in 1942, Doctor Davis interned for one year at Philadelphia General Hospital, and then took a year's fellowship at the Harrison Foundation Surgical Research, University of Pennsylvania. In 1943 Doctor Davis began a term as resident surgeon at the Philadelphia General Hospital, but this was interrupted by his service in the U. S. Navy Medical Corps, from 1944 to 1946, where he served with the rank of lieutenant. His naval service included duty in the Pacific Theater as a member of the surgical staff of the U. S. Navy Hospital Ship *Solace*, during the Philippines, Iwo and Okinawa invasions, and later serving at the Philadelphia Naval Hospital and the Navy Hospital at Norman, Oklahoma. Following his release from service, he completed his term as resident surgeon at the Philadelphia General Hospital, and then completed fellowships in surgery at the Cleveland Clinic, from 1947 to 1948, and at the Lahey Clinic from 1948 until March 1949.

Course in Gastro-Intestinal Surgery

The National Gastro-enterological Association, in cooperation with the Postgraduate Division of Tufts College Medical School and the First and Second Surgical Services of the Boston City Hospital, announces a course in gastro-intestinal surgery to be given at the Boston City Hospital, Boston, on October 27, 28, 29, 1949.

The course will cover various phases of gastro-intestinal surgery. It will be under the personal direction of Dr. Owen H. Wangenstein, Professor of Surgery, University of Minnesota Medical School, assisted by Lord Alfred Webb-Johnson, President of the Royal College of Surgeons, London, England, and the members of the surgical staff of the Boston City Hospital, as well as other distinguished guests.

Enrollment in the course is limited to 250. The fee will be \$35.00 per person. Veterans may take this course under the G.I. Bill of Rights. For further information and enrollment write to the National Gastro-enterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

Dr. George S. Bond, of Indianapolis, was elected president of the Indiana Heart Foundation, Inc., recently. Other officers of the foundation, all of whom were re-elected, are Ernest M. Hawkins, Fowler, vice-president; Kenneth R. Miller, Indianapolis, secretary; and Russell L. White, Indianapolis, treasurer. Mrs. Grace Tanner is executive secretary. Members of the board of directors are: Drs. Bond, Robert M. Moore, Kenneth G. Kohlstaedt, Cyrus J. Clark, and Donald E. Wood, all of Indianapolis; A. N. Ferguson, Fort Wayne; George M. Cook, Hammond; Walter S. Fisher, Columbus; Harry P. Ross, Richmond; and Stuart Combs, Terre Haute.

COMING MEDICAL MEETINGS

Indiana State Medical Association, Indianapolis, September 26, 27, 28, 29, 1949.

American Medical Association, Annual Session, Atlantic City, June 6, 7, 8, 9, 10, 1949.

American Academy of Neurology, French Lick, Indiana, French Lick Springs Hotel, June 1-3. Dr. Joe R. Brown, 19 Millard Hall, University of Minnesota, Minneapolis 14, Secretary.

American Academy of Tuberculosis Physicians, Atlantic City, Hotel Dennis, June 4. Dr. Oscar S. Levin, P. O. Box 7011, Denver 6, Colo., Secretary.

American Association of Railway Surgeons, Chicago, Drake Hotel, June 30-July 2. Dr. Chester C. Guy, 5800 Stoney Island Ave., Chicago 37, Secretary.

American College of Radiology, Atlantic City, Chalfonte-Haddon Hall, June 5. Mr. William C. Stronach, 20 N. Wacker Drive, Chicago 6, Secretary.

American Congress of Physical Medicine, Netherland Plaza, Cincinnati, September 6, 7, 8, 9, 10, 1949.

American Gastro-Enterological Assn., Atlantic City, Claridge Hotel, June 3-4. Dwight L. Wilbur, M.D., 655 Sutter St., San Francisco 2, Secretary.

American Neurological Association, Atlantic City, June 13-15. Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secretary.

American Ophthalmological Society, Hot Springs, Va., The Homestead, June 2-4. Dr. Maynard C. Wheeler, 30 W. 59th St., New York, Secretary.

American Proctologic Society, Columbus, Ohio, May 31-June 4. Dr. W. Wendell Green, 1838 Parkwood Ave., Toledo 2, Ohio, Secretary.

American Radium Society, Atlantic City, June 5. Dr. Hugh F. Hare, 605 Commonwealth Ave., Boston 15, Secretary.

American Society for the Study of Sterility, Atlantic City, N. J., June 6 and 7, 1949. W. W. Williams, M.D., Secretary, 20 Magnolia Ter., Springfield, Mass.

American Therapeutic Society, Atlantic City, June 2-5. Oscar B. Hunter, M.D., 915 Nineteenth St., N.W., Washington, D. C., Secretary.

Association for the Study of Internal Secretions, Atlantic City, June 3-4. Dr. Henry H. Turner, 1200 N. Walker St., Oklahoma City 3, Secretary.

Society for Investigative Dermatology, Atlantic City, Ritz Carlton Hotel, June 11-12. Dr. S. William Becker, 55 E. Washington St., Chicago 2, Secretary.

Society of Biological Psychiatry, Atlantic City, Chalfonte-Haddon Hall, June 12. Dr. George N. Thompson, 1136 W. Sixth St., Los Angeles, Secretary.

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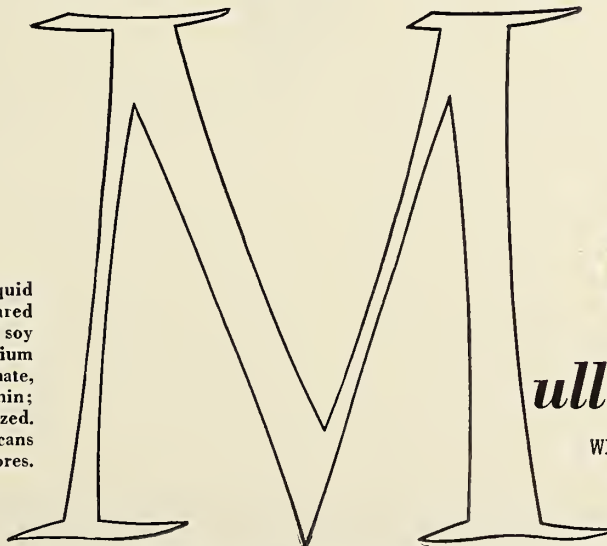
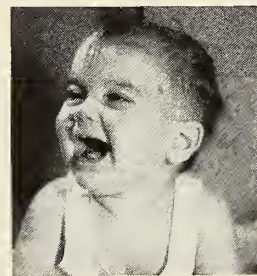
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INDIANA UNIVERSITY NEWS NOTES

Selection of 150 students from more than 1,000 applicants for admission this fall to the Indiana University School of Medicine was announced recently by Dean John D. Van Nuys.

The 150 students, all except seven of whom are from Indiana, will constitute the second expanded class designed to take care of qualified applicants and to provide the state with more physicians. The normal capacity of the University's medical school permits admission of only 128 students each year. Expansion of the 1948 and 1949 entering classes was made possible through additional funds for laboratories and staff which were allocated last year by Governor Ralph F. Gates and the State Budget Committee and specifically appropriated at the recent legislative session.

Dean Van Nuys described the class as one of "outstanding ability chosen with painstaking care" by the 14-member faculty committee on admissions. It, with the class admitted last fall, will be required to take some courses during the summer due to the school's physical plant limitations. Seven women students are included among the 150 accepted.

Those selected for admission as freshman medical students this fall on the Bloomington campus are:

Wallace M. Adye, Jr., Newtonville; Allen Wayne Aldred, Vevay; France Alexander, Gary; Ernest Anderson, Jr., Decatur; Berj Antreasian, Indianapolis; Charles H. Aust, Evansville; Thomas F. Ball, Connersville; Walter Joseph Banke, East Chicago; Donald T. Bartlett, Selma; Billy Jack Bauman, South Whitley; Gilbert B. Bluhm, Freelandville; Paul S. Bourne, Nappanee; Harry D. Brickley, Jr., Bluffton; Neel H. Bronnenberg, Anderson; Beverley Lee Bronstein, Huntington; Richard A. Burns, Keystone; Jack A. Bush, South Bend; Herman R. Casdorff, Indianapolis; John R. Cassady, South Bend; Thomas C. Chael, Kouts; Nicholas Christoff, Fort Wayne; John H. Coleman, Madison; Jean Craton, Vincennes; John R. Crist, Marion; Wayne A. Crockett, West Terre Haute; Gene Clayton Cunningham, Bloomington; Joseph N. Dill, Jr., Winamac; Raymond J. Doherty, Gary; Byron C. Doran, Burket; Richard R. Downing, Elkhart; Philip L. Ensey, Rockville; John J. Farrell, Jr., Bedford; Frederick W. Flora, Frankfort; John D. Franz, Greenfield; Jack Lee Frazier, Indianapolis; Paul S. Frey, Valparaiso; Matthew Joseph Fujawa, Mishawaka; Roy Lee Fultz, Salem; Lindley L. Gammell, Franklin; Charles N. Geyer, Boonville; Eugene M. Gillum, Richmond; Ted L. Grayson, Sharpsville; William E. Greer, South Bend; Hubert N. Grimes, Indianapolis; Robert A. Gunzenhauser, Fort Wayne; David B. Haggard, Indianapolis; Alvin J. Haley, Fort Wayne; Richard C. Haller, Fort

Wayne; Gilbert L. Hamilton, Bloomington; Leslie Hampton, Indianapolis.

Audrey Hancock, Indianapolis; William K. Haney, North Vernon; William L. Harritt, Indianapolis; Carl E. Heaton, Bloomington; William C. Heilman, New Castle; Kermit Q. Hübner, Indianapolis; Lloyd L. Hill, Indianapolis; Paul E. Hooley, LaGrange; Richard L. Huffer, South Bend; Walter L. Huit, Indianapolis; Joe G. Jontz, Silver Lake; George B. Keenan, Indianapolis; David B. Kenney, Indianapolis; Jack I. Kenzler, West Lafayette; James E. Keplinger, Markle; Raymond K. Kincaid, Jamestown; Robert E. Klausmeier, Evansville; Gerald Klooster, Munster; Robert W. Kohne, Decatur; Gabriel Kourany, Ancon, Canal Zone, Panama; Charles J. Kramer, Linton; Roland C. Kreps, Jr., South Bend; Lester E. Kron, Elizabeth; Archie John Krsek, Knox; Ardis Ray Lavender, Bloomington; John O. Lawrence, Terre Haute; Byron S. Lingeman, Crawfordsville; Ralph B. Lingeman, Jr., North Manchester; Robert W. Loudon, Shelbyville; Paul J. Lundergan, Washington; Frank E. Lundin, Decatur; Raymond C. Malone, Anderson; LaVonne Mannfield, Indianapolis; Leo Dale Marvel, Indianapolis; Gerald B. Mason, Fort Wayne; Warren E. Mayes, Terre Haute; Edward D. Miller, Danville; Harold L. Miller, Brazil; John D. Miller, North Manchester; Wayne O. Montgomery, Evansville; Martha Neal, Marion; Donald A. Nemer, Mishawaka; John W. Nelson, Hagerstown; Jerome E. Neustadt, Evansville; Douglass L. North, Mishawaka; Catherine Orr, Muncie; Milford D. Panzer, Newark, N. J.; Frank E. Pate, Marion; Leo G. Perucca, Terre Haute; Paul C. Peters, Greentown.

Joseph B. Peterson, Terre Haute; Peter R. Petrich, West Terre Haute; Dudley A. Pfaff, Jr., Indianapolis; Pearl Heber Pferson, Anderson; William Prudich, Powellton, W. Va.; William D. Ragan, Indianapolis; John C. Ralston, Jr., West Lafayette; John R. Read, Chesterton; Raymond L. Reed, Indianapolis; Floyd L. Rheinheimer, Goshen; Norval S. Rich, Berne; James O. Roberson, Bloomington; Robert E. Roberts, Toledo, Ohio; Sheldon Roger, Gary; Joe E. Rogers, Muncie; Kenneth J. Rudolph, Boonville; John P. Salb, Jasper; Richard B. Schnute, Evansville; Wayne Schrepferman, Brazil; George W. Sellmer, Indianapolis; Wesley E. Shannon, Crawfordsville; Paul P. Shelton, Jr., Madison; Albert G. Shoptaugh, Jr., Indianapolis; John H. Shroff, Nashville; Fred Silverman, Miami Beach, Fla.; William Sims, Indianapolis; Roy M. Smith, Jr., Newburgh; Marvin V. Snell, Warsaw; Parker W. Snyder, Indianapolis; Glenn H. Speckman, Indianapolis; Robert Stein, Newark, N. J.; Robert M. Stoltz, Valparaiso; James J. Sullivan, Royal Center; Chester R. Szalony, Hammond; Robert E. Talbert, Russiaville; Richard A. Taylor, Portland; Claude N. Thompson, Rockville; Joseph F. Thompson, Indianapolis; Robert P. Ulrey, Seymour; Leonard A. Vest, Connersville; Lloyd A. Vogel, Jr., Plymouth; Milton S. Wahl, Wilmington, Del.; Guy H. Waldo, Jr., Muncie; Thomas M. Walker, Mt. Vernon; Robert F. Walter, Evansville; Bernard K. Weiner, Gary; Frances Williams, Covington; Waymond B. Wilson, Pleasant Lake; Norman F. Wong, Palmyra; Wayne B. Zook, Nappanee.

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Murphy, F. D.: Wisconsin M. J. 42: 769 (1943).

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Rackemann, F. M.: J.A.M.A. 114: 1998 (1940).

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Deaths

John Clarence Kincaid, M.D., of Columbus, died on May 9, at the age of sixty-nine. He had practiced medicine in Columbus and Taylorsville for eighteen years, and prior to that had practiced in Indianapolis and Mooresville for thirty years. Doctor Kincaid graduated from the Eclectic Medical College of Indiana, in Indianapolis, in 1906, and was a member of the Bartholomew-Brown County Medical Society, the Indiana State Medical Association, and the American Medical Association.

James L. Lewis, M.D., formerly of Rockville, died in Danville, Illinois, on March 29, following a short illness. He was seventy-six years of age. Doctor Lewis graduated from the Northwestern University Medical School, in Chicago, in 1901. He was a member of the staff of the Indiana State Sanitarium at Rockville from 1944 to 1947. He was a member of the Parke-Vermillion County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Aron J. Lauer, M.D., retired physician of Whiting, died on April 30 after a long illness. He was seventy-seven years of age. He was a graduate of the Bennett College of Eclectic Medicine and Surgery, of Chicago, in 1893, and had practiced medicine in Whiting for fifty years. Doctor Lauer had retired in 1943 and moved to Lewisburg, Pennsylvania, but returned to Whiting four years ago. He was an honorary member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Alpheus LeRoy Thurston, M.D., of Indianapolis, died on April 24, at the age of sixty-five. A graduate of Indiana University School of Medicine in 1910, Doctor Thurston had practiced in Indianapolis for thirty-five years. He was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—MARCH 1949

Diseases	Mar. 1949	Feb. 1949	Jan. 1949	Mar. 1948	Mar. 1947
Brucellosis	3	2	0	7	10
Chickenpox	531	524	681	668	503
Conjunctivitis	13	10	1	2	5
Diphtheria	32	29	38	37	52
Encephalitis	2	2	6	7	10
Erysipelas	1	4	2	2	2
Impetigo	1	1	3	3	2
Influenza	40	52	134	42	1250
Malaria	1	0	0	0	5
Measles	582	372	267	3454	244
Meningitis,					
Unclassified	3	6	9	6	12
Influenza	2	2	3	2	1
Meningococcus	2	8	4	1	3
Pneumococcus	1	1	2	0	0
Encephalo-meningitis	1	0	0	0	0
Mumps	184	163	193	811	248
Paratyphoid fever	1	0	0	0	0
Pneumonia	60	151	83	43	93
Poliomyelitis,					
Paralytic	2	2	2	2	0
Rabies in animals	75	74	83	73	--
Rheumatic fever	1	3	2	0	0
Rubella	85	70	12	25	1
Scabies	3	6	4	5	0
Scarlet fever	394	284	250	298	544
Septic Sore throat	9	1	0	1	24
Tinea capitis	19	72	5	13	22
Tuberculosis,					
Pulmonary	171	244	238	136	222
Other forms	19	15	16	4	8
Tularemia	4	2	1	1	4
Typhoid fever	5	3	3	1	8
Whooping cough	73	112	80	121	127
Trachoma	1	0	0	0	0

MONTHLY REPORT—APRIL, 1949

Disease	Apr. 1949	Mar. 1949	Feb. 1949	Apr. 1948	Apr. 1947
Brucellosis	7	3	2	3	5
Chickenpox	613	561	524	476	541
Conjunctivitis	13	13	10	0	1
Diphtheria	29	32	29	38	32
Dysentery, amebic	1	0	4	0	0
Encephalitis	2	2	2	5	1
Impetigo	1	1	1	1	5
Influenza	9	40	52	1	68
Infectious jaundice	1	0	0	0	0
Measles	1146	582	372	3353	504
Meningitis,					
Unclassified	8	3	6	6	12
Influenzal	1	2	2	1	2
Meningococcal	2	2	8	4	4
Pneumococcal	3	1	1	0	0
Meningococcemia	1	0	0	0	0
Mumps	339	184	163	643	276
Pneumonia	55	60	151	41	80
Poliomyelitis,					
Unspecified	1	0	1	0	0
Nonparalytic	1	0	0	2	0
Rabies in animals	95	75	74	80	...
Rheumatic fever	6	1	3	1	0
Rubella	419	85	70	28	9
Scarlet fever	309	394	284	210	437
Tetanus	1	0	0	0	0
Tinea capitis	13	19	72	15	31
Tuberculosis,					
Pulmonary	216	171	244	192	295
Other forms	10	19	15	23	11
Tularemia	6	4	2	1	1
Typhoid fever	5	5	3	3	12
Vincent's angina	1	0	0	0	0
Whooping cough	82	73	112	125	258



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COMMITTEE ON PUBLICITY

April 8, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Ray E. Smith, executive secretary; and Larry Richardson, field secretary.

The following "Hints on Health" news releases were approved:

Week of May 30, 1949—"Insomnia."

Week of June 6, 1949—"Wisdom of Age."

The committee listened to a report on the projected radio series costs, the figures estimating that cost as between \$800 and \$1,600. It was suggested the headquarters send out a letter to the component societies inquiring into their willingness to finance the purchase of radio time for such a projected series.

The committee approved the renewal of the A.M.A. radio series of transcriptions now being played on WFBM, Indianapolis, and chose as the new series, "Live and Like It."

A projected folder of the Indiana Mental Hygiene Society received the tentative approval of the committee, with the suggestion that it be sent for final approval to the Executive Committee.

The subject of a press and radio get-together with the medical profession was discussed, the conclusion being that county societies should undertake such a party rather than to hold one central meeting in Indianapolis at which attendance from far-away points would probably be poor.

The following speaking engagements received the approval of the committee:

March 26, 1949—Regional Conference of Boys' Clubs, Indianapolis. "Interest in Unfortunates," association attorney.

March 29, 1949—Kiwanis Club, Greenfield. "Progress in Medical Care," association attorney.

April 4, 1949—Robinson-Ragsdale Post, American Legion, Indianapolis. "The Future Is Bright," association attorney.

April 7, 1949—Fountain-Warren County Medical Society, Kingman. "Compulsory Sick-ness Insurance," association attorney.

April 13, 1949—Business and Professional Women's Club, Huntington. "Socialized Medicine," field secretary.

April 15, 1949—Rotary Club, Lebanon. "Compulsory Sickness Insurance," association attorney.

April 19, 1949—49'ers Club, Indianapolis. "Socialized Medicine," field secretary.

April 20, 1949—Hayward-Barcus Post No. 55, American Legion, Indianapolis. "The Future Is Bright," association attorney.

April 18, 1949—Woman's Auxiliary, Legion Post No. 3, Indianapolis. "How Free Is Government-Free Medicine?," executive secretary.

April 20, 1949—Parent-Teacher Association, School 15, Indianapolis. "How Free Is Government-Free Medicine?," executive secretary.

April 21, 1949—Indiana Association of Podiatrists, LaPorte. "Socialized Medicine," field secretary.

April 22, 1949—Quincy Club, Speedway City, Indianapolis. "Socialized Medicine," field secretary.

May 11, 1949—Parent-Teacher Association, School 66, Indianapolis. "How Free Is Government-Free Medicine?," executive secretary.

COUNCILOR DISTRICT MEETING

SIXTH DISTRICT

Dr. Walter U. Kennedy of New Castle was re-elected Councilor, and Greenfield was selected as the 1950 meeting place at the annual Sixth District Medical Society meeting at New Castle May 4.

Dr. A. P. Hauss of New Albany, president of the Indiana State Medical Association, and Ray E. Smith, executive secretary, spoke at the noon luncheon. Dr. Will Thompson of Liberty, society president, presided.

The scientific program was as follows:

"Malignancies of the Esophagus and Stomach," by Dr. Sam A. Overstreet of Louisville, Kentucky.

"Indications of Caesarean Section," by Dr. Robert C. Long of Louisville, Kentucky.

"Congenital Cysts of the Head and Neck," by Dr. Bert E. Ellis of Indianapolis.

"Diet Therapy in the Management of Cardiovascular Renal Disease," by Dr. Richard S. Griffith and Mrs. Kathryn Sheedy, Lilly Laboratory for Clinical Research, Indianapolis.

The program also included a report by Doctor Kennedy and a welcome by Dr. Kenneth G. Hill of New Castle, president of the Henry County Medical Society.

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY

President, Guy A. Owsley, Hartford City,
President-Elect, N. Kemper Venis, Muncie,
Secretary, Joseph H. Clevenger, Muncie,
Treasurer, William J. Molloy, Muncie.

FLOYD COUNTY MEDICAL SOCIETY

President, Herbert Sloan, New Albany,
Vice-President, John P. Gentile, New Albany,
Secretary-Treasurer, Robert E. LaFollette, New Albany.

GRANT COUNTY MEDICAL SOCIETY

President, Asher D. Huff, Marion,
Vice-President, Lester L. Renbarger, Marion,
Secretary-Treasurer, Russell W. Lavengood, Marion.

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*Based on average reported values for milk.

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Clinton County Medical Society members met at Frankfort on April 5. The fifteen members who were present heard Drs. Robert Hedgecock, George K. Hammersley and Paul Van Kirk, all of Frankfort, report on the recent annual meeting of the Chicago Medical Society.

Carroll County Medical Society members met at the Delphi Country Club on April 20. Fifteen members were present.

Elkhart County Medical Society members held a meeting at the Hotel Elkhart in Elkhart on April 7. The guest speaker was Dr. Ben Goodrich, of the Cardio-respiratory Division of the Henry Ford Hospital, in Detroit, who spoke on "Physiological Therapy of Coronary Artery Disease." Fifty-five members attended this meeting.

Fayette-Franklin County Medical Society members met at the Country Club in Connersville on April 12. Dr. James C. Katterjohn, of Indianapolis, was the guest speaker. His subject was "Cancer of the Cervix."

Greene County Medical Society members met at the Freeman Greene County Hospital in Linton on April 14. This was a business meeting, and thirteen members were present.

Hamilton County Medical Society members held a meeting in Cicero on April 15. Dr. John M. Young, of Indianapolis, spoke on "Conservative Renal Surgery." Sixteen members were present.

Hendricks County Medical Society members met at Merritt's Restaurant, in Avon, on April 5, when twenty-one members were present. At this meeting the Woman's Auxiliary to the Hendricks County Medical Society was organized.

At another meeting on May 4, ten members were present to hear Mr. Larry Richardson, field secretary of the state association, speak on pending medical legislation. At this meeting the doctors' wives organized the Woman's Auxiliary to the Hendricks County Medical Society.

Howard County Medical Society members met in Kokomo on April 1. The twenty-six members who were present heard Dr. Sprague H. Gardiner, of Indianapolis, speak on "Psychiatric Aspects of Gynecology."

Huntington County Medical Society members held a meeting in Huntington, on April 5. Mr. Harry E. Northam, of Chicago, executive secretary of the American Association of Physicians and Surgeons, spoke on "What A.A.P.S. Is and Does." Eighteen members attended this meeting.

Another meeting was held on May 3. This was a business meeting and nineteen members were present

LaPorte County Medical Society members met at the Peacock Fountain Inn, in Rolling Prairie, on April 21. The speakers for the evening were Mr. Joseph Sheerin, who spoke on "The Blue Cross Plan"; and Mr. Al Spiers, of *The Michigan City News Dispatch*, who spoke on "Public Relations and the Press." Thirty-seven members were present.

Madison County Medical Society members met at the Anderson Country Club on April 18. Thirty-eight members and three guests were present. The guest speaker was Dr. Dan Barrett, of Indianapolis, who spoke on "Relations Between Board of Health and County Health Office."

Montgomery County Medical Society members held a meeting at Culver Hospital in Crawfordsville on April 21. The twenty-six members who were present heard Dr. Byron K. Rust, of Indianapolis, speak on "Therapy in Pediatric Practice."

At another meeting on March 18, the thirty-two members present heard Drs. Earl W. Mericle and C. Basil Fausset, of Indianapolis, speak on "Recent Developments in Psychiatry and Neurosurgery."

Morgan County Medical Society held a meeting at the Memorial Hospital, in Martinsville, on April 16. Dr. E. M. Pitkin, of Martinsville, spoke on "Basic Principles of Electrocardiography." Seven members were present.

Orange County Medical Society members met at the West Baden Springs Hotel on April 5. Sixteen members were present. Dr. David Adler, of Columbus, spoke on "Cystologic Diagnosis of Malignancy."

Owen-Monroe County Medical Society members met at the Bloomington Country Club on April 29. Thirty members were present, to hear Professor Robert Milisen, Ph.D., chairman of the Speech and Hearing Clinic at Indiana University.

Tippecanoe County Medical Society members met at Lincoln Lodge in LaFayette, on April 12. The guest speaker was Dr. Samuel G. Plice, of Chicago, whose subject was "Pathologic Physiology of Heart Failure and Its Relationship to Treatment." Fifty members were present.

Vanderburgh County Medical Society met on April 12 at the McCurdy Hotel in Evansville. Dr. Edward P. Cawley, assistant professor of dermatology and syphilology at Michigan University Hospital, Ann Arbor, spoke on "Cutaneous Manifestations of Internal Disorders." Seventy members were present.

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President—Mrs. Truman Caylor, Bluffton.

President-elect—Mrs. D. E. Lybrook, Galveston.

Corresponding Secretary—Mrs. Harry Harvey, Fort Wayne.

Recording Secretary—Mrs. Bert Ellis, Indianapolis.

Treasurer—Mrs. Wendell Kelley, Anderson.

Press and Publicity—Mrs. Claude S. Black, Warren.

The fifth annual session of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association was held in Huntington, April 26 and 27. Mrs. W. R. Morrison, state president, presided at all the meetings, which opened with a Musical Tea at 4 p.m. on Tuesday, at Hotel LaFontaine. At the banquet at 7 o'clock, Dr. Claude S. Black, president-elect of the Indiana State Medical Association, extended greetings to the 125 members and guests. Mrs. Morrison introduced the special guests, which included Mrs. E. Benjamin Gillette, Toledo, Ohio, immediate past president of Ohio state auxiliary; Mrs. George Cooperrider, Columbus, Ohio, newly installed president-elect of the Ohio group, and Mrs. Harold F. Wahlgvist, Minneapolis, president of the Minnesota auxiliary, who addressed the group on Wednesday at the noon luncheon, which carried out the Mexican motif in decorations, which Mrs. Morrison purchased on her recent trip south of the border.

Dr. Augustus P. Hauss, New Albany, president of the Indiana State Medical Association, was the guest speaker. He gave a very informative and inspiring talk. He challenged the auxiliary members to be envoys of good will. He also paid tribute to the work being carried on by the auxiliary.

The following officers were elected: President-elect, Mrs. D. E. Lybrook, Galveston; First vice-president, Mrs. P. J. Coultas, Tell City; Second vice-president, Mrs. W. Burleigh Matthew, Indianapolis; Third Vice-president, Mrs. F. M. Fargher, Michigan City; Fourth Vice-president, Mrs. Robert Bolin, Elkhart; Corresponding Secretary, Mrs. Harry Harvey, Fort Wayne; Recording Secretary, Mrs. Bert Ellis, Indianapolis; Treasurer, Mrs. Wendell C. Kelley, Anderson.

The delightful two day session closed on Wednesday afternoon, following the installation of all new officers.

Mrs. Truman Caylor accepted the gavel from Mrs. Morrison and in her acceptance speech she commended the House of Delegates' unanimous stand against socialized medicine, as voiced in the resolution passed by the assembly, and added that it is a fight to save American freedom.

REPORT OF PRESIDENT

Mrs. W. R. Morrison

Members of the House of Delegates to the Woman's Auxiliary of the Indiana State Medical Society, it is with a feeling of pride and satisfaction that I am able to bring you this report. Our membership has increased by over 150 new members, making a total of almost

1,850. We have seven new auxiliaries, one of which was a group which was inactive for a number of years. We now have forty auxiliaries with 46 counties, or 50 percent, of the counties of the state organized. In the last two years we have organized 15 new auxiliaries. We have more members than either Illinois or Michigan and our percentage of doctors' wives organized is higher than Ohio.

I have visited 29 of the auxiliaries this year, attended the convention of the Woman's Auxiliary to the A.M.A., and the Conference of State Presidents, both held in Chicago. I was a guest of the Michigan Auxiliary last fall, and the Ohio state meeting last week. I have presided at all of the board meetings.

It has been a great pleasure to meet the wives of the physicians throughout the state and learn of the fine leadership and splendid work being done. Many of the younger wives are accepting places as presidents and are doing a fine job, in spite of the visitation of the stork in several instances.

This year there has been one theme I have discussed which embraces program, public relations, and legislation, and that is compulsory health insurance, or socialized medicine. I am sure we are all better informed and realize how important our contacts are with other groups. I have made a number of talks before different lay organizations. The public is waking up to this threat, and none too soon.

I would like to point out the splendid activity of the Montgomery County group. Although organized only a little over a year ago, I found them especially well informed and anxious to do their part.

Hygeia subscriptions have shown an increase, totaling well over \$800, and *The Bulletin* has also shown an increase, in spite of National's policy. Until National can send every member her copy, let me urge that at least the president and program chairman take this publication.

Of the auxiliaries reporting, twelve offer scholarships for nurse's training in varying amounts. Many sponsor teas for high school girls interested in nursing as a profession.

Many auxiliaries have sponsored public meetings, with talks on socialized medicine or voluntary insurance plans, such as Blue Cross or Blue Shield.

There is a great opportunity to use the radio for health talks and speeches against socialized medicine. We need more trained personnel to put on real live shows.

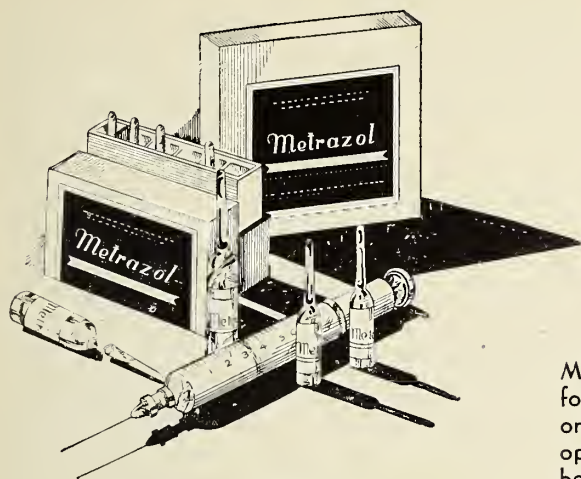
I should like to especially commend the work of the legislative chairman, Miss Schuler. She has visited many auxiliaries, spoke before public gatherings, and gave much important information to all the groups. Other state legislative chairmen have written for suggestions. May I urge every auxiliary to subscribe to the Marjorie Shearon Service for up-to-the-minute news on legislation.

It has made me very proud of our *Hoosier Doctor's Wife* when auxiliary members from other states have praised our publication, and I wish to express my appreciation for a job well done by the editor, Mrs. A. W. Ratcliffe.

The Program Chairman, Mrs. D. E. Lybrook, has served long and faithfully on our board and we have received requests from other state program chairmen regarding her displays.

May I give thanks to our state Parliamentarian, Mrs. Charles F. Voyles, for her helpfulness and kind advice throughout the year.

The speaker for the Ohio state luncheon last Wednesday suggested a plan to which we can all subscribe. Let every auxiliary member, every doctor's wife, and every doctor, be a committee of one to secure 20 people to write to their congressmen and to the President, pro-



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May I, in closing, say that I am deeply grateful for the opportunity of serving in this capacity, and I promise you I shall always treasure your many kindnesses and tokens of friendship and your fine spirit of cooperation.

REPORT OF ORGANIZATION CHAIRMAN

Mrs. Truman Caylor

This year, as your president-elect and state organization chairman, I have a brief report to make to you in both capacities. You have heard the report of the four vice-presidents, who make up my organization committees. This report then should be a summary of their good work and of others who helped us to accomplish these things, plus my small part.

We have a total to date of 7 new organizations, representing 8 new counties listed, in the order of their organization:

1. **Rush County** came first with eighteen members. Mrs. R. B. Johnson is serving as their first president.

2. **Benton County** is unique, in that their president, Mrs. L. P. Muller, reports over 100 percent membership.

3. **Huntington County** was organized in November at a luncheon given in the home of the wife of the president-elect of the Indiana State Medical Association, Mrs. Claude S. Black. Mrs. Howard Marks is serving as their president, and Mrs. Marks is also chairman of this House of Delegates meeting. For a group organized only six months, I would say this is a large undertaking and I would say they are all duly initiated.

4. One week later came **Dubois County**, in the southern part of our state. Mrs. Bretts, president, regrets so very much she could not be with us. Amy Lee Coultas, Ethel Gastineau and I had luncheon with the Dubois group when they organized and their southern hospitality made it a thrilling event.

5. The same day in November, Vivien Morrison and Ruth Ellis went to Bloomington to talk organization to **Owen-Monroe Counties**. Later, they, too, organized, with Mrs. Dillon Geiger as president.

6. One day in February Isobel Shinabery and I went to Marion to talk to a group for **Grant County**. A week later Mrs. Lester Renbarger, as their president, reported a paid-up membership of 23.

7. Now our youngest organization, **Hendricks County**, came into the fold on April 5. Mrs. Gastineau went to organize this group alone, since at the last moment, on account of a death in my family, I could not join her. Ethel reports Mrs. Scamahorn was elected their president.

This makes the seventh new auxiliary and the eighth county to organize to date.

Now amidst these more interesting events, the committee had other things to do, such as collecting dues from Members-at-Large, sending out notices in January and February, and I sent out 600 cards, many with personal notes added, besides answering all personal letters. Most of these were answered by letter or card and I have found many counties interested and seriously considering organization.

There are at the present time approximately 8 more counties on the verge—and the M.A.L. dues are still coming in.

Many of our M.A.L.'s have gone into the new county groups, so to date we have 85 M.A.L.'s and a total membership in the state of 1830.

We have tried especially hard this year to get new members and Helen Kelly, our treasurer, reports 251 paid-up NEW members.

Before the state convention in October, I talked to Ray Smith, the executive secretary of the I.S.M.A. and to Mrs. Morrison, and we tried to plan some way to have each doctor's wife and every guest feel welcome to attend the social functions of the auxiliary during the convention, whether members or not. So we put out 1,000 attractive invitations, which were handed to every doctor at registration. This was purely an experiment. How much it helped, we cannot know. However, there were 600 at the tea and we had several sign up for membership at the luncheon meeting, so we feel it helped to some degree.

There was a National Conference in Chicago in November for presidents and presidents-elect, which Vivien Morrison and I attended. This was a very informative and instructive two-day meeting. We had the most forceful speakers I have ever been privileged to hear and came home full of inspiration, hopes and plans.

Of course, there were national reports to get out, with several maps of Indiana to be colored. We also went to all the sessions of the national auxiliary and A.M.A. meetings in Chicago in June, 1948.

Last week Vivien and I were invited by Mrs. Gillette, president of the Woman's Auxiliary to the Ohio State Medical Association, to come to Columbus to attend the state meetings of their Woman's Auxiliary. We thoroughly enjoyed every minute of our stay, and came home with a wealth of new ideas, some of which I am hoping to use this coming year. We witnessed a beautiful memorial service, heard inspirational speakers, and enjoyed Mrs. Gillette's hospitality more than I can say. Mrs. Gillette had appointed a hospitality committee to see that all out-of-state guests were personally taken care of. They made a delightful party of each event.

I want to take this opportunity to tell you all how much I enjoyed working with you, and especially my committee, Isobel Shinabery, Amy Lee Coultas, Betty Wagoner and Bea Baxter, who have helped make this an especially pleasant year.

NECROLOGY LIST

Memorial Service given by Mrs. Marion Hillman, of South Bend, assisted by Mrs. E. C. Singer, Fort Wayne, and by Mrs. D. E. Lybrook, of Young America, Indiana.

Mrs. A. L. Mikesell, Allen County, Fort Wayne
Mrs. J. S. Slabaugh, Elkhart County, Nappanee
Mrs. F. C. Deilman, Fulton County, Fulton
Mrs. L. M. Knepple, Howard County, Kokomo
Mrs. John W. Carmack, Marion, Indianapolis
Mrs. M. J. Spencer, Marion County, Indianapolis
Mrs. Jesse L. Jackson, Marion County, Indianapolis
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Books

BOOKS RECEIVED

AESCULAPIUS COMES TO THE COLONIES—The Story of the Early Days of Medicine in the Thirteen Original Colonies. By Maurice Bear Gordon, M.D. 560 pages, with 107 illustrations. Cloth. Price \$10.00. Ventnor Publishers, Inc., Ventnor, New Jersey, 1949.

FROM THIRTY YEARS WITH FREUD—By Theodore Reik. 241 pages, cloth. Price \$3.75. International Universities Press, Inc., New York, 1949.

THE USES OF PENICILLIN AND STREPTOMYCIN—By Chester Scott Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, 72 pages. Cloth. Price \$2.00. University of Kansas Press, Lawrence, Kansas, 1949.

FUNDAMENTALS OF INTERNAL MEDICINE—3rd Edition. By Wallace M. Yater, M.D., Director, Yater Clinic, Washington, D. C. 1,451 pages, with 315 illustrations. Cloth. Price \$12.00. Appleton-Century-Crofts, Inc., New York, 1949.

HANDBOOK OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY—For Students and Practitioners of Medicine. By Forrest Ramon Davison, Ph.D. 4th Edition. 730 pages, with 35 illustrations, including 4 in color. Cloth. Price \$8.50. The C. V. Mosby Co., St. Louis, 1949.

CARE OF THE SURGICAL PATIENT—Including Pathologic Physiology and Principles of Diagnosis and Treatment: By Jacob Fine, M.D., Surgeon-in-Chief, Beth Israel Hospital; Professor of Surgery at Beth Israel Hospital, Harvard Medical School. 544 pages with 40 figures. Cloth. Price \$8.00. W. B. Saunders Company, Philadelphia and London, 1949.

CLINICAL AUSCULTATION OF THE HEART—By Samuel A. Levine, M.D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital; and W. Proctor Harvey, M.D., Research Fellow in Medicine, Harvard Medical School Assistant in Medicine, Peter Bent Brigham Hospital. 327 pages with 286 figures. Cloth. Price \$6.50. W. B. Saunders Company, Philadelphia, 1949.

BOOKS REVIEWED

THE PSYCHOANALYTIC READER. An Anthology of Essential Papers with Critical Introductions. Edited by Robert Fliess, M.D. 392 pages. Cloth. Price \$7.50. International Universities Press, Inc., New York, 1949.

The book consists of a compilation of psychoanalytic papers, the contributions having been selected after scanning the complete literature in the psychoanalytic field. A considerable number of the papers have not previously appeared in English and certain of the papers have notes or emendations added to them by the authors themselves. The papers on Female and Preodipal Sexuality, written by Helene Deutsch, J. Lampl deGroat and Ruth M. Brunswick, should be digested by every psychiatrist. The papers in this book will be of value to the student of psychoanalysis and should serve as excellent references to every psychiatrist who is interested in analytic theory and practice.

ANESTHESIA, PRINCIPLES AND PRACTICE. A Presentation for the Nursing Profession. By Alice Maude Hunt, R.N. 148 pp. 7 illustrations. Fabrikoid. Price \$2.60. G. P. Putnam's Sons, New York, 1948.

There is great need for a good introductory text on anesthesiology for nurses. This book fails to satisfy that need. Chapter V, which discusses General Immediate Preoperative and Postoperative Care is well presented. The rest of the book is characterized by oversimplification, circumlocution, lack of clarity, and poor organization. The stages of anesthesia are limited to three, and stage III is divided into three planes. We now recognize four stages of anesthesia, and stage III is divided into four planes. Discussion of this fundamental and important concept and of the signs of anesthesia is too brief. Space is used to detail outmoded techniques, such as dental extraction with undiluted nitrous oxide and the use of ether as an intravenous anesthetic. Indications and contraindications of agents are not clearly brought out and often not mentioned. Situations with dangerous potentialities are limited to the stomach containing food, to vomiting, and to explosions. Respiratory and circulatory complications of anesthesia should be discussed.

The style of the author is rather loose and conversational and adds to the appeal of the book as a reflection of her many years of experience. As a text and reference there is little value.

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RIGHTS OF TAX OFFICIALS IN REGARD TO RECORDS OF PHYSICIANS

BYRON B. EMSWILLER*

Indianapolis

THERE are two situations in which a physician may be confronted with a question regarding the right of employees of the Federal Revenue Department, and of the State Gross Income Tax Division, to see the books and records in a physician's office.

The first of the situations exists when the subject of inquiry is the income of the physician himself, whose books such government employees desire to examine.

The second is when such government employees desire to examine the books and records of a physician to ascertain facts concerning a patient of the physician.

Each of these two situations will be discussed; first, under the State Gross Income Tax Law, and second, under the Federal Revenue Laws.

I.

UNDER THE STATE GROSS INCOME TAX LAW

A.

WHERE THE PHYSICIAN'S OWN INCOME IS UNDER INQUIRY

The Gross Income Tax Law does not set out what records must be kept by a taxpayer. It merely states that every taxpayer shall keep such books or accounts as may be necessary to determine the amount of tax due. In a general way, of

course, all taxpayers will keep a record of their cash receipts, and, if they report on an accrual basis, of their accounts receivable. But some taxpayers will be required to keep more detailed records than others, particularly when "contra" accounts are involved. By contra accounts is meant when two taxpayers have transactions with each other which result in tax liability on the part of both taxpayers even though no cash may actually exchange hands.

The law provides that records of income shall be kept for a period of three years, which means that a record which shows income received on January 1, 1945, cannot lawfully be destroyed until January 31, 1949. The annual return for the year 1945, which includes the income for the year 1945, is due and payable on or before January 31, 1946, and three years from the date the annual return is due is the time when the records no longer need be kept.

A failure to keep books or records is punishable as a misdemeanor and a fine can be imposed not to exceed \$500.00. All records which are necessary to determine the amount of tax due must be kept available for inspection by the authorized agents of the Department. All agents of the Department carry a card issued by the Department showing their authority to examine a taxpayer's books and records. Before a taxpayer displays any records or books to anyone representing himself to be an agent of the Department, the taxpayer should request that he be shown the person's

*Tax Attorney

authorization to act for and on behalf of the State of Indiana.

If a taxpayer refuses to allow an authorized agent of the Department to examine his books and records, the Department has the power to issue a subpoena ordering the production of the books and records, and failure on the part of the taxpayer to comply with the order of the subpoena is punishable by a contempt proceeding instituted in a circuit or superior court. Through this subpoena power the Department can examine bank records and records in the possession of other taxpayers to verify the taxpayer's returns which are under scrutiny.

Although an authorized agent of the Department can examine all records of a taxpayer pertaining to his income, any information he gleans can lawfully be disclosed only to employees of the Department. A violation of this section of the law makes the employee of the Department subject to a fine and imprisonment. This provision of the law protects taxpayers from having business secrets divulged to competitors and the general public.

B.

WHERE THE INCOME OF A PATIENT IS UNDER INQUIRY

In isolated instances an inspection of physician's records might be desired by the Department to ascertain the income of a patient. For example, a patient may have failed to keep any records, or his records may be deemed to be false by the Department. To attempt to verify the returns filed by the patient the Department may wish to ascertain the amount of expenditures made by the patient. By ascertaining the amount of income needed to meet the patient's expenditures the Department may estimate the amount of income the patient received.

Inasmuch as the doctor's records pertaining to income are subject to examination by the Department any portion of his income records can be examined, and, therefore, his records pertaining to one particular patient can also be examined. The physician can be compelled to allow an authorized agent to examine any and all records pertaining to his own income even though this examination gives the Department data as to amounts paid the physician by a patient.

Under the Indiana law the information received from the patient by a physician as such, is privileged, and a physician cannot be forced to bear witness against his patient on items in which a physician-patient relationship is involved. For this reason the agents of the Gross Income Tax Division have no right to examine any records of the physician pertaining to the diagnoses of the cases, the treatments given, or the medicines prescribed. The doctor at all times should bear

in mind that this information is confidential between himself and the patient, and that fact may properly be called to the attention of the tax man.

Some physicians follow the practice of showing on a patient's card the diagnosis, history of the case, and treatment given; and on the same card the amounts charged the patient and amounts received from the patient. The agents of the Income Tax Division are entitled to know the name and address of the patient and the amount of money paid by him to the physician, but the remainder of the information on the card is confidential and the agent has no right or authority to inspect this other data. When this situation exists it would be good procedure for the physician to conceal the confidential information from the tax man by lining out the information or covering it with a blotter, a card or some device whereby this portion of the card cannot be inspected by him.

The better method of keeping records when a card system is used is by preparing two cards for each patient. One of these cards could show the charges made and payments received. The other card could contain all other information of a confidential nature other than information pertaining to the income of the patient. By using a two card system the cards showing only the financial data can be turned over to the agent without further ado, and the physician or his office help do not have to be fearful about divulging confidential matter to the tax man.

The taxing authorities, since they have the power to inspect all records reflecting income, usually desire to see the books of original entry rather than data drawn from the original books, and for this reason all books and records of original entry should be maintained and kept by the physician for the statutory period. Whenever fraud is involved or when a taxpayer fails to file a return, the statutory period of three years does not run against the Department, and the Department can make assessments without any statute of limitation running against it. The penalty for fraud under the act is 50 percent of the tax due, plus interest at the rate of 1 percent per month, plus a fine and imprisonment. Whenever a taxpayer fails to keep records required by the act, that is, records which will reflect his tax liability, the Department can prepare a return from the best information available and such return in the eyes of the law is *prima facie* correct. The burden then is on the taxpayer to prove that such return prepared by the Department is erroneous, which proof is very difficult to obtain if there are no books or records to sustain the contention of the taxpayer.

Section 24, Gross Income Tax Act

Section 26, Gross Income Tax Act

Section 27, Gross Income Tax Act

Regulation 401, Gross Income Tax Act

II.

UNDER THE FEDERAL REVENUE LAWS

A.

WHERE THE PHYSICIAN'S OWN INCOME IS
UNDER INQUIRY

While the state taxing authorities are primarily interested in gross income, and they seldom examine records pertaining to expenditures, the federal taxing authorities are interested in the computation of net income, and they scrutinize all expenditures and deductions on the tax returns.

The Federal Income Tax Law has a provision similar to the provision in the state law, in regard to the requirements concerning books and records, but the application of the provision is vastly different as between the two divisions of Government. Under the Federal Act the taxpayer must keep such accounting records as will enable him to make a return of his true income. But, of course, the "income" here means net income, while the liability under the state act is based primarily on gross income.

Among the essential records to be kept are inventories taken at the beginning and end of the taxable year when the production, purchase or sale of merchandise is an income producing factor. If a physician keeps a stock of medicine from which he makes sales to his patients then it is necessary for the physician to take inventories at the beginning and at the end of the year. The physician must keep a record of all expenditures made in connection with his profession and these items must be segregated as to capital items and expense items. A capital expenditure would be an item which is subject to depreciation. If the physician purchased equipment which is to be used in connection with his profession and has a useful life of five years, the cost of the equipment item must be kept and depreciated over the five year period. The expense items, such as office rent, lights, water, etcetera, are all taken off of the income at the end of the year. In case an item of equipment is being recovered through depreciation or obsolescence, any expenditure other than ordinary repairs made to prolong the useful life of the capital item must be added to the cost of the capital item in the capital item's depreciation, and should not be put in the list of current expenses.

Under the law and regulations the Commissioner can require that a taxpayer keep any records which are necessary to the verification of a taxpayer's return, and after the Department audits a taxpayer's records it may require certain subsidiary records to be kept and maintained by the taxpayer.

The agents of the income tax division are authorized to inspect all records of a taxpayer which tend to prove or disprove a return, and, if a return is not filed, to examine records to prove what the tax return should have reflected.

The agents can inspect records of inventories, all facts of income and expenditures, and all facts pertaining to capital items. The agents can physically examine items of equipment and other physical property for the purpose of evaluating depreciation and obsolescence and for any other purpose pertaining to the income tax returns.

Through the subpoena power the agents may examine records in the hands of persons other than the taxpayers themselves. For example, the bank statements and bank records of a physician may be inspected for the purpose of verifying the physician's return. All public records, of course, are open for inspection, and frequently when the agents suspect that a taxpayer has failed to keep proper books and records, they inspect records in county offices and wherever else they are available to ascertain the extent of holdings of the taxpayer. In short, it seems correct to say that all records of a public or private nature, except where a confidential relationship recognized by law exists, may be inspected by the agents of the Tax Department to verify a taxpayer's taxable income and the figures reflected on returns filed, provided the records are such as could throw any light on the facts regarding income.

The widest scope of inquiry generally results where the government has found some reason to believe that the net worth of the taxpayer has increased more than they believe would be possible if the true facts of his net income were reflected in his income tax returns.

The Federal Income Tax Law provides that when there is a willful failure to keep adequate records and supply adequate information, the taxpayer may be fined up to \$10,000.00 and imprisoned for not more than one year.

B.

WHERE THE INCOME OF A PATIENT IS
UNDER INQUIRY

The physician has the same duty to his patients under the Federal Net Income Tax Act as he has under the State Gross Income Tax Act. It is the duty of the physician to keep confidential any information pertaining to the patient's ailments, treatments given, and any other information the physician has received in his capacity as a physician serving the patient professionally.

In addition to verifying a patient's gross income by examining a physician's records regarding amounts paid the physician by a particular patient, the Federal Government might have need for examining the physician's records because of the additional deduction allowed under the federal law. Under the law one is entitled to deduct extraordinary medical expenses, i.e., when the medical expenses are in excess of 5 percent of the taxpayer's total income. The federal authorities might have need to examine a physician's

records to verify this deduction on the patient's return.

The same policy should be followed in regard to federal income tax examiners as with state income tax examiners; and if all the information concerning a patient is kept on one sheet or card it would again be good procedure to allow the

federal inspector to examine only the part concerning charges and payments, and to refrain from allowing the inspector to examine entries concerning diagnoses, treatments and other information of a personal nature.

Internal Revenue Code, Section 29.41

Internal Revenue Code, Section 145(a).

IF I WERE A PHYSICIAN SELECTING DISABILITY INCOME INSURANCE

RICHARD A. CALKINS*

INDIANAPOLIS

THE daily orbit of the physician in private practice today appears to consist of hospital rounds, house calls, crowded office hours and a fleeting visit to the arms of Morpheus. Rarely can he take time for deliberation on matters of personal economic security. All time and energy is demanded for rehabilitating patients, to the end that they may pursue, among other things, their economic salvation. The doctor's needs are handicapped.

Restricting this situation to the subject at hand, how shall the busy physician go about selecting disability income insurance that will serve him adequately if the dizzy whirl forces him into the ranks of those to whom he ministers? How can he conserve his time and yet make sure that his protection is right?

If I were a physician selecting disability income insurance under the circumstances named, I first would select my insurance adviser, then lean upon him heavily. Most physicians know several life insurance agents whose counsel they value. One of these life agents, especially if his life insurance company does not offer accident and health insurance, can render invaluable and *unbiased* aid in the selection of disability protection to fit the need. Since life insurance is his main line, he is not likely to recommend disability protection of low standard because that would jeopardize his life insurance business.

Every life insurance adviser worthy of the name has a healthy interest in guiding his clients to dependable disability protection. He knows that the most carefully constructed program of life insurance for the protection of the physician's family and the assurance of income for retirement may be dissipated during a long period of disability, through the cash or loan values, if there is no disability income coverage.

In selecting your insurance adviser, there is the possibility that you will encounter an "Eager Beaver" who promptly scents some additional money that he thinks he may be able to maneuver into an additional life insurance policy. If you realize that it is more tragic to become dependent on your dependents during a long period of disablement than it is to die and leave those dependents nothing, you will know how to deal with the "beavers." No one can gainsay the fact that dependents can shift for themselves alone more readily than they can provide for themselves and a disabled breadwinner, too.

In selecting your adviser in the matter of disability insurance, you will wish to avoid the life insurance agent who "specializes" in life insurance and does not "find the time to know about disability insurance," because this agent is not concerned with your personal economic security as much as he is interested in selling what he has to sell.

The "Eager Beavers" and the "Specialists" are very much in the minority. The chances are overwhelmingly in favor of your first selection among the life insurance advisers in your acquaintance being a person who will promptly review the field and bring you the best policies available for your particular needs. By a telephone call you can put him to work on the problem.

When your adviser has selected the policy which he thinks is best for your situation, there are a few questions you should ask him. Is it noncancelable and guaranteed renewable to a specific age, at a fixed or level premium? If not, you should require such coverage; otherwise the protection can be withdrawn, and more than likely will be after a claim of consequence, at a time when you are uninsurable and in great need of it.

Another question: does it require house-confinement in order to qualify for the full indemnity

* President, Disability Income Insurance Co.

over a long period of disability? Such a provision can give you the choice of virtual imprisonment or the wind-up of the indemnity in a brief space of time.

Does the policy contain an incontestable clause? Your life insurance policies have such a provision, and it is equally important on your disability policies.

Are premiums waived during a protracted period of disability? If premiums must be paid during a long period of disability, as much as 10 percent of the indemnity received may have to be reinvested in order to continue the protection.

Is a medical examination required at the time of application? If not, you may find that the real underwriting of the risk has been delayed until the time of claim. That can be disastrous for the policyholder. A medical examination does much to put the burden of proof where it belongs: on the insurance company.

Does the policy have gadgets such as double indemnity for injury under certain unusual or special circumstances? The manner in which you become disabled has nothing to do with the amount of indemnity you will need. Such features add to

the sales appeal and to the premium, but do not accurately serve your needs.

If the above questions about the policy are satisfactorily answered, there is practically no chance that you will make an unwise choice. With the right life insurance adviser on the case, there is little likelihood that his recommendation will not stand the test of these questions.

If you are presently paying premiums on accident and health policies, have your life insurance adviser check these and determine whether they afford quality protection. If the advice in this article seems sensible to you, it is possible that you will wish to clip it from the pages of your copy of *THE JOURNAL*. After you have put it to current use, you may wish to have it filed for future reference.

Editor's Note:—Mr. Calkins has supplied reprints of an article written by Mr. Albert Stump, legal counsel for the association, and published in the November, 1947 issue of *THE JOURNAL*. The article, entitled "Loop-Holes in Disability Insurance," has been re-published in other medical journals and contains additional facts pertinent to the selection of disability protection. Address *THE JOURNAL*, 1017 Hume-Mansur Building, Indianapolis, for a copy.

QUESTIONS WANTED FOR PANEL DISCUSSIONS

Physicians are invited to submit questions on the subjects of "Peripheral Vascular Diseases" and "Hospital Rules and Regulations," which will be discussed by panels on Wednesday afternoon, September 28, and Thursday afternoon, September 29, respectively, during the annual session.

The questions should be mailed to Dr. Ralph U. Leser, chairman of the Committee on Scientific Work, 207 Hume Mansur Building, Indianapolis 4, who will turn them over to the moderators. Receipt of the questions prior to the meeting will enable the panel leaders to present a more interesting program.

ESTATE CONSERVATION

PARKER T. SPINNEY*

WABASH

"ESTATE CONSERVATION" is a planned program to reduce death taxes, through study of assets from a standpoint of liquidity and yield with results tailored to the family need.

Today's estate requires the same attention and management as business to assure the greatest benefits possible for heirs at minimum cost. The estate owner is forced to defend his accumulations against many external factors, such as taxation, economic trends, investments, human weaknesses, and so forth. These problems cannot be ignored nor postponed without jeopardizing the financial condition of the family.

The basic changes in estate and gift taxes under the 1948 Revenue Act render the majority of existing estate plans obsolete, but, I would say, have offered a special premium on tax-wise plans to married people. The Federal estate tax rates have not been changed, but a marital deduction has been added. It provides a marital deduction up to 50 per cent of the adjusted gross estate. This deduction is allowed in general for "outright bequests" and for "property placed in trust" under certain conditions.

It automatically takes property out of the top bracket in a deceased's estate and, when the survivor has a moderate-sized estate, will be taxed in a lower bracket. In other words, the community property benefits have been extended to all states and are a factor in estate conservation which should be duly considered but not taken arbitrarily.

The 1948 Revenue Act can be used to increase substantially the amount of property available to your wife and children. For example:¹

A. The Federal Estate Tax on \$120,000 net estate before the Act was \$9,500. If half of the estate is left outright to the surviving spouse, under the marital deductions of the new Act, the tax will be zero. If the property received from the first spouse had the same value on the death of the second spouse, no further Federal Estate Tax would be payable. The full marital deductions would save \$9,500 in Federal Estate Taxes.

B. The Federal Estate Tax on a \$200,000 estate is \$31,500 without marital deductions, and \$4,800 with marital deductions. If the property received from the first spouse had the same value on the death of the second spouse, the Federal Estate Tax would be \$4,800. The marital deductions would save \$26,700.

C. The Federal Estate Tax on a \$400,000 estate is \$87,700 without marital deductions, and \$31,500 with marital deductions. If the property received from the first spouse had the same value on the death of the second spouse, the Federal Estate Tax would be \$31,500. The full marital deductions would save \$56,200.

D. The Federal Estate Tax on a \$600,000 estate is \$145,700 without marital deductions, and \$59,100 with marital deductions. If the property received from the first spouse had the same value on the death of the second spouse, the Federal Estate Tax would be \$59,100. The full marital deductions would save \$86,600.

¹ We assume the wife has no property in her name at death of husband.

The foregoing examples are only in the nature of a guidepost. The marital deductions will depend upon many factors: the size of separate estates; the availability of liquid assets; the possibility of undue influence being brought upon the survivors, and their ability to recognize that certain privileges were granted for tax-wise purposes. If the wife has a larger estate than the husband, it is quite possible that the marital deduction would be a disadvantage tax-wise. It is quite possible, however, that consumption of principal and/or gifts could be deliberately planned to the family by the survivor in order to reduce the taxable estate, and thereby justify a marital deduction.

FEDERAL ESTATE TAXES

The following table brings out savings available if the estate can be handled on the maximum marital deduction basis:

Adjusted Gross Estate	A Without Marital Deduction	B With Marital Deduction	C Maximum Savings By M. D.
\$ 120,000	\$ 9,500	\$ 0	\$ 9,500
200,000	31,500	4,800	26,700
300,000	59,100	17,500	41,600
400,000	87,700	31,500	56,200
500,000	116,500	45,300	71,200
600,000	145,700	59,100	86,600
700,000	176,700	73,300	103,400
800,000	206,900	87,700	119,200
900,000	238,900	102,100	136,800
1,000,000	270,300	116,500	153,800

A. Federal Estate Tax where decedent was unmarried or, if married, has left nothing to surviving spouse, either outright or in another manner qualifying for marital deduction.

B. Federal Estate Tax where decedent was married and left estate to the surviving spouse, either outright or in another manner qualifying for marital deduction.

C. Maximum savings by marital deduction.

* Counselor, Estate and Tax Conservation.

GIFTS

The Revenue Act has also amended the gift tax provisions to correspond with the changes in the estate tax law. This law provides that a husband may give property to his wife and be taxed only on one-half the value received. The one-half is a "marital deduction."

If a man gives his wife \$100,000, his net taxable gift could be figured as follows:

Amount of Gift-----	\$100,000
Marital Deduction -----	\$50,000
Lifetime Exemption -----	30,000
Annual Exclusion -----	3,000
	<hr/>
	\$ 83,000
	<hr/>
Net Gift Subject to Tax-----	\$ 17,000

The *marital deduction* is computed on the entire *value* of the property transferred and without regard to the annual exclusion. Otherwise, if a man transfers \$20,000 to his wife, the marital deduction will be \$10,000, and in computing the gift tax, deducts \$3,000 for the annual exclusion, leaving a net gift of \$7,000 subject to tax. An estate owner may give his spouse \$66,000 without tax because the lifetime exemption and annual exclusion will completely exempt his one-half.

The *split income law*, however, eliminates all income tax savings from "gifts to wives" and, in some instances, nullifies estate tax savings. The *increased tax advantage* available for "*Gifts to Children*" are, therefore, a major factor in estate conservation.

This law provides that a gift by either spouse to a third person can be considered as made one-half by the husband and one-half by the wife. This type of gift usually involves children, because an estate owner may give \$6,000 a year to each child, free of gift tax, if both spouses agree to the gift treatment. For example:

If three children were given \$6,000 a year for ten years, \$180,000 could be transferred free of both estate and gift taxes. If the man is now worth \$600,000, the estate tax savings alone would be approximately \$54,000.

The income tax savings from this gift could also be very attractive. For instance:

A. The income tax would have been removed from the parents' top bracket to a much lower bracket of the children.

B. If the child's income is under \$500, it is exempt from tax, and, at the same time, the parent could take a \$600 exemption for each child. If the child's income exceeds \$500, the exemption is not available to the parents.

C. If the parents' net income is in excess of \$10,000, then a net savings of 10 per cent could be realized on all income over that amount shifted to the children because the law allows an automatic standard deduction of 10 per cent of adjusted gross income up to \$10,000. This applies to children even though they might not have any regular deductions.

INSURANCE

Many parents create reserve funds to help their children in business or to assist in raising families. If this type of gift were made in the form of a life insurance contract on the child's life, a substantial income tax savings can be achieved because the income increment in the contract will be wholly exempt from income tax.

The estate owners will find that the best vehicle in most cases is a life insurance contract on the child's life. This is especially true where the insured is a minor. It eliminates the necessity of appointing a guardian for the insured, which should be done if the child receives property in virtually any other form. There is an expense connected with a guardianship and a guardian must report to the court every two years.

The marital deduction applies to insurance for estate tax purposes the same as any other property. The deductions are not allowed if the decedent gives his wife merely an interest for life, with the remainder to contingent beneficiaries. The wife must have the right to all the amounts payable during her life and unconditional power to appoint any insurance benefits to herself or to her estate.

The majority of people will be required to change the settlement options on their life insurance policies to take advantage of the marital deduction. One must consider the possibilities, therefore, of having one member of the family insure the life of another. The wife, with an independent income, and the husband may insure the life of each other in anticipation of a tax problem upon their deaths.

The insurance is one of the best forms of property in which to invest surplus dollars. It not only produces cash but guarantees income when needed.

JOINTLY HELD PROPERTY

There is a widespread misconception that jointly held property results in an automatic transfer to the survivor free from transfer tax. This is not true. The Federal Estate Tax is levied according to the consideration furnished by the deceased. If the husband paid the entire purchase price from his individual funds, the entire value is included in his estate.

For gift tax purposes the purchase of property by the husband for himself and his wife constitutes, as a rule, (exception: U. S. Savings Bonds) a gift of one-half interest of the property. It would be entitled to the marital deductions as it represents a gift from husband to wife.

CHARITABLE GIFTS

Gifts or bequests to charitable, educational or similar organizations are now free from Federal estate or gift tax. The gift, however, must be certain and not subject to revocation.

CONCLUSION

Conservation of economic values of a family from one generation to the next requires the service of a man who occupies the place similar to a specialist in the medical or legal profession.

These counselors avail themselves of the most accurate and complete information obtainable and

have trained themselves to present the individual with an entirely unbiased opinion. Such a counselor does not pretend to replace the lawyer or trust officer. His business is to inform and stimulate a client to the point where he will recognize his estate problems and cooperate in whole with the attorney and trust officer to complete the job.

THE INDIANA PUBLIC HEALTH CODE

(Senate Bill 39; Chapter 157, Indiana Acts of 1949)

THE organization of 68 state health laws into a single law or code was accomplished by the 1949 Indiana General Assembly. This procedure of codification follows a pattern of recent years, both in Indiana legislation and that of other legislative bodies throughout the country, as a means to simplify understanding and interpretation of the law in specific fields.

For many years the need for organization and clarification of our numerous public health laws in Indiana has been felt keenly by health officers, doctors and other public health personnel charged with the responsibility of carrying out the intent of these laws. This can be understood readily when it is observed that over 100 public health laws have been passed by our Indiana General Assembly since the original basic health law of 1881, without any codification or organization of these laws during this interim of 68 years. Many of these laws have been passed with little thought of their effect on prior laws, and the inevitable result has been duplication, overlapping, ambiguity and a considerable amount of confusion. As an example of this point, the various health laws, up until codification, contain about 40 separate penalty provisions, with the result that there were frequently different penalties fixed for the same violation of law. In addition, there were many separate definitions of the same term, duplication of provisions, and instances where older laws had been modified or superseded directly or by legal implication by subsequent laws.

The first action toward clarification of the public health laws was taken by the State Board of Health in August, 1947, when arrangements were made with the Bureau of Government Research of Indiana University to study the problem and make recommendations. During the course of this study, the problem was discussed with the Governor and the staffs of the Legislative Bureau and Attorney General's office. This resulted in general agreement that an advisory committee of representative citizens should be formed to supervise the project. On the basis of this, the Governor appointed 40 well-known citizens of the state to a Public Health Code Committee, including Dr. J. William Wright and the late Dr. Norman M.

Beatty. This committee, in its first meeting, enunciated a plan to collect the public health acts into an organized code with the elimination of duplication, overlapping and the clarification of ambiguity in so far as could be done without making material change in the substance of the laws as they existed. Intensive work by competent legal, technical and professional individuals was then required to complete this defined objective during the following eight months.

In the completed Code, 64 laws and parts of 4 other laws were collected according to content into five major groups. Each group was set up in a separate "article." Miscellaneous laws were collected in a sixth "article." The following table of contents indicates the form of the Code and the content of the various articles and subdivisions:

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In numbering the actual sections of the Code, a key system was generally followed. This accounts for the fact that although the last section is numbered 2403, there are actually only 520 separate sections.

During the formation of the code, the Public Health Code Committee, appointed by the Governor, was of invaluable assistance in keeping the project in line with the original plan and objective to "Collect the public health acts into an organized code, eliminate duplication, overlapping, and clarify ambiguity in so far as could be done without making any material change in the substance of the law as it existed." The code was passed by the 1949 Indiana General Assembly with only one minor amendment and with an emergency section providing for an effective date, July 1, 1949.

The preparation of this proposed Public Health Code represents a noteworthy achievement in teamwork between many citizens and agencies having as their single objective the ultimate improvement of the environment in which we live, with the consequent attainment of improved health for all.

It is felt that the 1949 General Assembly has made a distinct contribution toward the improvement of public health administration in Indiana.

NARCOTIC "DON'TS" FOR THE PHYSICIAN

Don't leave prescription pads around. (Addicts want them for effecting narcotic forgeries.)

Don't write a narcotic prescription in lead pencil. (Avoid writing any Rx in pencil; many are changed to call for morphine.)

Don't write for narcotics this way: Morphine HT½ #X or Morphine HT½ #10. (Several X's or zeros can be added to raise the amount. Use brackets or spelling.)

Don't carry a large stock of narcotics in your bag. (Addicts are on the lookout for these in doctor's offices and cars.)

Don't store your office supply where patients can get at it. (Avoid storage near sink or urinal. The patient may ask for use of these.)

Don't fall for a good story from a stranger claiming ailment that usually requires morphine. (The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.)

Don't give a narcotic Rx to another without seeing the patient. (Addicts have posed as nurses to get doctors to prescribe narcotics.)

Don't write large quantities of narcotics unless unavoidable. (Diversion to addicts is a profitable business, as much as \$1.00 for ½ gr. M. S.)

Don't prescribe narcotics on the story that another M. D. had been doing it. (Consult that physician or the hospital records whenever possible.)

Don't leave Rxs signed in blank at the office for nurses to fill in. (Signed blanks are bad practice and many have been stolen by addicts.)

Don't treat an ambulatory case of addiction. Addicts must be under proper control. (Addicts go to several M. D.'s at a time. Notify this Bureau.)

Don't dispense any narcotics without keeping a record of it. (Bedside and office administration are permitted without record.)

Don't buy your office narcotic needs on Rx blank in name of patient. (The law requires you to use an official order form.)

Don't resent a pharmacist's call for information about an Rx you may have written. (The pharmacist is held responsible for filling forgeries. Please cooperate.)

Don't hesitate to call this Bureau to get or give information. (Information will be held strictly confidential by members of this Bureau.)

Write: Mr. Paul Brigham, Narcotic Agent,
214 Federal Building,
Indianapolis 4, Indiana.

MARRIAGE LAWS

THE part of the marriage laws of special interest to physicians is the Act of 1939, which provides for serological tests for syphilis. The Act is short but it contains a number of points on which physicians frequently seek information. The number of inquiries made by physicians regarding various elements of this law justifies the printing of the text of the law as the body of this article. It reads as follows:

"(1) No application for a marriage license shall be accepted by the clerk of the circuit court unless accompanied by or unless there shall have been filed with him a statement or statements signed by a duly licensed physician that each applicant has been given such examination including a standard serological test as may be necessary for the discovery of syphilis made on a day specified in the statement which shall be not more than the thirtieth day prior to that on which the license is applied for, and that in the opinion of the physician the person thereon named is not infected with syphilis or if so affected, is not in the stage of that disease whereby it is communicable at such time. Any such blood test shall be performed in the laboratory of the state board of health of the state of Indiana or in a laboratory or laboratories meeting standards prescribed by the pathology department of Indiana University School of Medicine and approved by the Indiana state board of health.

"(2) Because of emergency or other causes shown by affidavit or other proof, the judge of the circuit court of the county in which the application for such license is made, on joint application of both of the parties desiring the marriage license, shall without the intervention of a jury, in court or in chambers, during the term or in vacation, if satisfied that the public welfare and health will not be injuriously affected thereby, make an order, in his discretion, dispensing with the requirements of subdivision one of this section as to either or both of the parties, including the laboratory statement specified below, or, in the event the statement or statements provided for by such subdivisions have been filed, then by extending the thirty (30) day period following the examination and test to not later than a day specified, which, however, shall be not more than ninety (90) days after such examination and test. The order shall be accompanied by a memorandum in writing by the judge reciting the reasons for granting the order. In case of pregnancy, such judge may order the issuing of such license after the blood test and the physician's certificate has been exhibited to him. Application for such extension may be made before, on or after the expiration of such thirty (30) day period.

Such order, and the accompanying memorandum, shall be filed with the clerk of the circuit court of such county and he shall then accept and consider such application for such marriage license without the production or filing of any of the physician's statements dispensed with by this order, or shall accept and consider the application within such extended period, as the case may be. The clerk of the circuit court shall hold such memorandum of the judge in absolute confidence and the same shall not be considered as a public record, and all communications with reference thereto shall be construed to be privileged communications.

"(3) Each such physician's statement shall be accompanied by a statement from the person in charge of the laboratory making the test, or from any other person authorized by such person to make such statement, setting forth the name of the test, the date it was completed and the name and address of each person whose blood was tested, but not stating the results of the test. The physician's statement and laboratory statement shall be on the same form sheet. Upon a separate form a detailed report of the laboratory test, showing the result of the test, shall be transmitted by the United States mails to the physician, who after examining it, shall file it with the state board of health, and it shall be held in absolute confidence and shall not be open to public inspection: Provided, That it shall be produced for evidence at any trial or proceeding in any court of competent jurisdiction, involving issues pertaining only to said marriage contract on an order of the judge of such court requiring its production and shall not be competent as evidence in any trial or proceeding in which said marriage contract is not involved.

"(4) A standard serological test shall be a laboratory test for syphilis approved by the state board of health and shall be performed as provided for in this act. All laboratory specimens for such tests shall be transmitted by such physicians to the laboratories through the United States mail.

"(5) Any applicant for marriage license, any physician or any representative of a laboratory who shall misrepresent any of the facts required by such physician's statement and such laboratory statement or report, or any licensing officer who shall have reason to believe that any of the facts have been misrepresented and shall nevertheless in such case issue a marriage license, or any official or employee who shall not hold the laboratory record confidential except as provided in subdivision three (3) hereof with respect to its production for evidence, or any clerk of a circuit court or any deputy or

employee of any such clerk who shall not hold in strictest confidence the statement filed with him as to the reasons for the granting of an order under subdivision two (2) shall be guilty of a misdemeanor and shall be punished by a fine of not more than one hundred dollars (\$100) to which may be added imprisonment not exceeding six (6) months.

"(6) Nothing in this section shall impair or affect existing laws, regulations or codes made by authority of law, relative to the reporting of cases of syphilis discovered by physicians, nor shall any person who has taken such test be compelled to submit to any medical treatment when such person objects to the same on religious grounds and who, in good faith, selects and depends upon spiritual means or prayer for the treatment or cure of disease.

"(7) The state board of health is hereby given authority to make rules and regulations for the administration of the provisions of this act as amended and the state board of health in conjunction with the pathology department of the Indiana University School of Medicine is hereby given authority to fix standards and to grant approval to laboratories performing such blood tests, and other laboratory tests of a public health nature."

(Burns 1940 Replacement, Section 44-213.)

The administration of the law and the almost universal compliance with it seem to have met with general public approval. It has served effectively as an aid in the education of the public regarding venereal diseases, particularly syphilis. No litigation has developed under the law which resulted in appeals to the Supreme or Appellate Court of Indiana. Requests for opinion of the Attorney General regarding the law were made in 1940 and 1941. The Attorney General in 1930 gave his opinion to the effect that the rules and regulations adopted by the Indiana State Board of Health in conjunction with the Pathology Department of Indiana University School of Medicine, as they related to this law, were legally authorized. (Opinions of Attorney General, 1940, page 161.)

In 1941, the Attorney General held that the State Board of Health was not authorized to adopt and enforce a resolution requiring laboratories making syphilis blood tests to defer return of results for twenty-four hours. (Opinions of Attorney General, 1941, page 386.)

The remaining marriage laws may be summarized briefly as follows:

1. The man must be at least eighteen years of age, and the girl at least sixteen years.

2. They must not be nearer of kin than second cousins, although all marriages which took place before 1907 between first cousins were legalized in 1907.

3. If either party to the marriage had a hus-

band or wife living at the time of the marriage it is void.

4. When one of the parties is a white person and the other has one-eighth or more of negro blood the marriage is void.

5. When either party is insane or idiotic at the time of the marriage it is void.

(These void marriages are absolutely void without any legal proceedings.)

6. A marriage is voidable, but not absolutely void until made so by an order of the court, where either of the parties is incapable, from want of age or understanding, of contracting the marriage or when the marriage is procured through fraud of one of the parties, but the children of such marriage begotten before it is annulled are legitimate.

7. The children born of marriages which are void "on account of consanguinity, affinity, or difference of color" are legitimate, as a result of an Act of the Legislature in 1873. (Burns 1940 Replacement, Section 44-107.)

8. The children born of marriages which are void because of an undissolved former marriage are legitimate where the parties contracted such void marriage in the reasonable belief that the disability to marriage did not exist. (Burns 1940 Replacement, Section 44-108.)

9. A license need not be issued by the clerk without the consent of the parent or guardian if the girl is within the age of eighteen years or the boy within the age of twenty-one. But if there is no parent or guardian the clerk may issue the license to parties under the age limit upon an affidavit of a disinterested person to the effect that no parent or guardian resides within the state and that the girl has resided in the county where the license is sought to be obtained for one month preceding such application.

10. The clerk must not grant a license to marry where either of the contracting parties "is an imbecile, epileptic, of unsound mind, or under guardianship as a person of unsound mind; nor to any male person who is or has been an inmate of any county asylum or home for indigent persons, unless it satisfactorily appears that the cause of such condition has been removed and that such male applicant is able to support a family and likely to so continue; nor shall any license issue when either of the contracting parties is afflicted with a transmissible disease, or, at the time of making application, is under the influence of an intoxicating liquor or narcotic drug. (Burns 1940 Replacement, Section 44-207.)

This summary of the marriage laws of Indiana will indicate the scope of the marriage laws in which any medical question may arise. Integrity in the observance of the marriage laws of course

is required. The laws are sanctioned by penalties which apply to the clerk for the violation of his duties; to whoever solemnizes a marriage where he knows that the persons have not complied with the law or who fails to return the certificate; to whoever solemnizes a marriage without having authority to act in that capacity; and to whoever "procures the issuance of a license to marry by any false statement, representation or pretense." (Burns 1940 Replacement, Sections 44-204 to 44-306.)

Those who are authorized by law to solemnize marriages are "ministers of the gospel and priests throughout the State, judges of courts of record, justices of the peace, and mayors of cities, within their respective counties, and by the Friends Church and German Baptists according to the rules of their societies."

No marriage, however, is void on account of the incapacity of the person solemnizing it, nor is it "void or voidable for the want of license or other formality required by law, if either of the parties thereto believed it to be a legal marriage at the time."

Under the last provision common law marriages are recognized. The provision is only declaratory, however, of the common law, and in the absence of this provision in the statutes a common law marriage in Indiana would nevertheless be legal. A common law marriage takes place when a man and woman having the legal capacity to become husband and wife live together as husband and wife and hold themselves out to the world and represent themselves to be husband and wife, and at least one of the parties believes that they are husband and wife.

LAW PERTAINING TO NURSES

IN the 1949 Session of the Legislature a new law was enacted for the regulation of the practice of nursing. Under it a new Board was created, consisting of five members, to be known as the Indiana State Board of Nurses Registration and Nursing Education. The members to be appointed must have the following qualifications: citizenship of the United States and residency of Indiana; completion of four years of high school work; graduation from an accredited school of nursing; licensed as a registered nurse in Indiana; at least five years experience in nursing following graduation; at least two years executive or teaching experience in nursing; and active practice of nursing for two years immediately preceding appointment.

The Indiana State Nurses Association has the right to recommend to the Governor a list of its members qualified for appointment, consisting of not less than twice the number of vacancies to be filled. The Board has the power to make rules and regulations. It reports to the Governor and the State Budget Director.

The Board examines, licenses, and renews the licenses of duly qualified applicants, and suspends or revokes such licenses for cause. It keeps a register of names, addresses, dates of examination, and registration of nurses, with such other information as the Board may require. The curricula and standards of schools of nursing are prescribed by the Board, and it examines and accredits schools.

The Board is required to have an Executive Secretary, who is a graduate of an accredited school of nursing and of a college or university, and is a registered nurse with at least five years of experience in teaching and administration in an accredited school of nursing.

The Act defines the practice of nursing in two definitions. It is first defined as the performance by a registered nurse of "any professional services requiring the application of principles of the biological, physical and social sciences, and nursing skills in the care of the sick, the prevention of disease or in the conservation of health." In the second, it is defined as the performance by a licensed practical nurse of "such duties as are required in the physical care of a convalescent, a chronically ill or aged or infirm person, and in carrying out medical orders as prescribed by a licensed physician, requiring a knowledge of simple nursing procedures but not requiring the professional knowledge and skills required for professional nursing."

It would be somewhat difficult for a layman to comprehend clearly the lines of distinction between the two definitions. But the nursing profession no doubt has those distinctions in mind, for the Act was drawn in accordance with their ideas and was sponsored by the State Nurses Association.

For one to receive a license to practice as a registered nurse she must possess the following qualifications: be at least twenty years of age, of good moral character, a citizen of the United States or one who has declared her intention to become a citizen; completion of an approved four year high school course of study or the equivalent thereof; have such other preliminary qualifications as the Board prescribes, completion of the prescribed curriculum in an accredited school of nursing and the holder of a diploma therefrom. If the applicant satisfies these preliminary requirements, she must then pass a written examination, which may be supplemented by an oral or practical examination, all as the Board may determine. The

Board may issue a license to practice nursing as a registered nurse without an examination to registered nurses of other states, if the applicant meets the qualifications required of registered nurses in Indiana.

Upon obtaining a license to practice as a registered nurse the person may use the title "Registered Nurse" and the abbreviation "R. N." No other person is permitted to practice as a registered, certified, trained, or graduate nurse, or to use the abbreviation R. N., C. N., T. N., G. N., or any other designation to indicate that she is a registered nurse.

Those holding valid licenses or certificates of registration as registered nurses on July 1, 1949, are deemed licensed as registered nurses under the new Act.

Any one seeking a license to practice as a licensed practical nurse must: be eighteen years of age or over; be of good moral character; be a citizen of the United States or legally declared to be intending to become a citizen; and have completed such preliminary qualifications and requirements as the Board may prescribe, and also an accredited program for a licensed practical nurse, and have a diploma or certificate showing such completion.

One who has the qualifications just mentioned must pass a written examination, which may be supplemented by an oral or practical examination before the Board. If the examination is successfully passed a certificate is issued to the applicant to practice nursing as a licensed practical nurse. Certificates may also be issued without an examination to persons from other states, if they meet the requirements of the Indiana Board.

A person who obtains the license to practice as a practical nurse has the right to use the title "Licensed Practical Nurse" and the abbreviation "L. P. N." No other person has such right.

The registration fee for a registered nurse is \$15.00. The fee for a licensed practical nurse is \$10.00. The license must be renewed every year, and a failure to pay the fee automatically termin-

ates the license, which may, however, be reinstated upon payment of renewal fees.

The Board has the power to revoke licenses also where the licensee: has been guilty of fraud in obtaining a license, of a crime or of gross immorality; is unfit by reason of negligence, habit or other causes; is habitually intemperate or is addicted to habit-forming drugs; is mentally incompetent; is guilty of unprofessional conduct; or has willfully or repeatedly violated the Act.

The Act makes it a crime for any person to practice nursing "as a registered nurse or as a licensed practical nurse as defined by this Act unless duly licensed to do so under the provisions of this Act"; or to act in this capacity while her license is suspended; or to conduct a school of nursing unless the school has been accredited by the Board; or to violate any other provision of the Act. The penalty for such crime is a fine of not more than \$150.00 for the first offense; and not less than \$100.00 nor more than \$1,000.00, or imprisonment for not more than 180 days, or both fine and imprisonment, for any subsequent violation of the law.

Under this law no one is prohibited from performing whatever duties are required in caring for a patient or in following the orders and prescriptions of a physician, so long as the persons who do so who are not licensed under this Act do not assume the title nor hold themselves out as professional, registered, graduate, trained, or certified nurses, or as licensed practical nurses.

The Act manifests the purpose and intention of the nursing profession to elevate and maintain the standards of nursing for those who hold themselves out to the public as having the type and quality of training which certain titles they may assume would indicate that they possess. The purpose was generally approved and commended when the bill came before the Legislature. It was adopted with practically no opposition. It would seem that the enforcement of the law would be in the public interest and that there should be no serious difficulties encountered in its operation.



RULES AND REGULATIONS OF PUBLIC HOSPITALS

THE power of governing boards of county hospitals to make rules and regulations has been clarified by a recent decision of the Supreme Court of Indiana. The attorneys representing the physician involved in that case have announced their intention to seek to have the case reviewed by the United States Supreme Court on a petition for a writ of certiorari. Whether the United States Supreme Court grants or denies the petition is a matter resting within the discretion of that Court. But upon a previous decision by that Court it would seem the action of the Supreme Court of Indiana would be sustained by the United States Supreme Court if it decides to review the case, although it also seems that the possibility of obtaining a review by that Court is remote.

The parts of the rules and regulations involved in this litigation read as follows:

"Article V—Medical Staff. Section I. The Hamilton County Hospital Staff as a whole shall be made up of the following groups or divisions; (a) The Active Medical Staff, which shall consist of: (1) The Resident Active Medical Staff, which shall include all the physicians having an unlimited license to practice medicine in the State of Indiana *and having membership in Hamilton County professional organization of fully licensed physicians having the largest number of such physicians residing in Hamilton County * * **" (Our italics)

"(d) 2. All appointments to the staff and assignments to services shall be made by the Board of Trustees *but only upon the recommendation of the Active Medical Staff.* (Our italics.) The Board of Trustees will either accept the recommendation of the medical staff or refer it back for further consideration with a statement of its reasons for such action. When final action has been taken by the governing body the superintendent will be authorized to transmit its decision to the candidate and to the chief of staff * * *."

"Article VII—Choice of Physician or Surgeon—Section 1. Patients entering the hospital shall have the right to employ the physician or surgeon of their choice; Provided, that such physician or surgeon satisfies the standards of preparation herein stated for the service he is employed to render, and conforms to the following requirements and conditions. (1) He must have an unlimited license to practice medicine in Indiana * * * (3) He must be a member of the Hamilton County Hospital Medical Staff, hereinafter generally referred to as the staff, as constituted under these rules and regulations; or if he is not a member he shall comply with the following provisions: (a) He is required to have with him in the treatment of his case a physician who is a member of the staff and who satisfies the

rules and regulations as to qualifications to perform the services appropriate to the care and treatment of the patient. (b) He must, in arranging for admission of his patient, submit to the Superintendent, a written statement of the diagnosis he has made and the service he intends to render. (c) Upon receipt of such written statement, the Superintendent shall call in a member of the staff qualified to render the service mentioned in the written statement, which staff member shall have the right and duty to check the diagnosis and the services the non-staff physician proposes to render; and in event such staff member believes that said diagnosis to be incorrect the proposed treatment to be against the best interest of the patient, he shall so report to the Superintendent who shall transmit and explain to the patient such report. (d) The staff member called pursuant to (c) shall attend and be ready to assist in the rendering of any surgical or other services; and he shall be entitled to receive the same pay as he would receive for rendering the services himself which the patient receives from a non-staff physician and overseer. (e) The patient or the person responsible for the care of the patient who is admitted to the hospital with a non-staff physician attending him, shall be advised by the non-staff physician of all these requirements, including the obligation of the patient to pay the staff member; and the Superintendent shall have authority to make inquiries to determine whether or not such advice has been given and if she finds that it has not, then to give such advice herself. (4) A surgeon desiring to practice surgery who was not a member of the surgical staff of the hospital according to the records of the hospital on March 1, 1947, shall possess the following qualifications, in addition to those mentioned under 1 and 2: (a) He shall be a member of the staff. (b) He shall have a certificate of internship showing one year service as an interne in a hospital approved by the Council of Medical Education and Hospitals of the American Medical Association. (c) In addition to interne training required under (b) he shall have had not less than three years of surgical training which meets the approval of the American College of Surgeons."

In its opinion after the Supreme Court held that the rules might reasonably require membership on the staff of the hospital under the 1945 Hospital Licensing Law, it said regarding the rules of the hospital in this case:

"The present rules, however, provide that the hospital can appoint new members to its staff only upon recommendation of its staff. It would seem by this rule, recommendation to membership may be rejected by the board, but that no one shall be made a member of the staff without such recommendation. This is an unreasonable requirement,

as by it the hospital delegates to its staff a virtual veto of its right to perform one of its duties. By this arrangement the staff dictates what physicians may practice in the hospital. In so holding we are aware that courts of at least one other jurisdiction have approved of staff selection in public hospitals by invitation from their staff. See *Selden v. City of Sterling*, 1942, 316 Ill. App. 455, 45 N.E. 2d 329. With this holding we cannot agree."

The following further excerpts from the opinion are given in the belief that they may be of value to physicians who may be called upon to confer with governing boards of hospitals in the formulating of hospital rules and regulations:

"(4) It will be further noted that by the involved rules, appellee's right to practice in the hospital is not only conditioned on his being a member of the staff, but also on his being a member of the Hamilton County Medical Society, an extra governmental agency. His admission to this society depends entirely upon the sole determination of the society. Whether he could ever become a member depends upon conditions beyond his control. By this rule the hospital again delegates its power to determine what physicians may use its facilities. It amounts to a preference in favor of the society and a discrimination against those physicians who by choice or otherwise, are not members of the same.

"(5-8) The rule in question relating to surgery which requires a surgeon who was not a member of the staff on March 1, 1947, not only to be a physician licensed by the state, but to have had one year service as an interne in an approved hospital, and three years of surgical training which meets the approval of the American College of Surgeons, as applied to a public hospital such as here involved, is reasonable. We recognize the right of public hospitals to make and enforce reasonable rules for the protection of its patients. In fact such power is expressly conferred by the sections of our statutes above quoted. We judicially know,

and the testimony in this case amply illustrates, that a license to practice medicine does not guarantee that the holder thereof is capable of doing surgery. See *Green v. City of St. Petersburg*, 1944, 154 Fla. 339, 17 So. 2d 517, wherein reasons in defense of this proposition are well stated. It is true that part of what was said in the last cited case seems to have been said on the assumption that the maintenance of a public hospital by a municipality is not a governmental function which is contrary to the law of this state. Board of Com'rs of Greene County v. *Usrey*, 1943, 221 Ind. 197, 46 N.E. 2d 823. Nevertheless, without this assumption, the reasoning in the Florida case is sound. In oral argument it was also suggested that this rule as to surgery is discriminatory, as it does not apply to those physicians who were members of the staff prior to March 1, 1947. With this we cannot agree. Similar classifications have been upheld for legislative purposes.

"(9) As to the sufficiency of the evidence to support the finding, it is our opinion that the appellee is not qualified, under the valid portions of the rules now in force, to perform surgery in the hospital.

"We, therefore, reverse that portion of the judgment of the trial court which enjoins the appellants from preventing the appellee from doing surgery in the hospital, and affirm that portion of the judgment which enjoins the appellants from preventing the appellee under the present rules from practicing medicine in the hospital other than surgery."

The effect of this decision on existing hospital rules and regulations is to render unenforceable, not the rules and regulations of a hospital in their entirety, but only those portions of the rules and regulations which are in conflict with this opinion. And further, the law established by this opinion can be changed by a decision of the U. S. Supreme Court. While that is not anticipated, yet if it does occur an article will appear promptly thereafter in *THE JOURNAL* calling attention to that decision.



THE COLLECTION OF PHYSICIANS' ACCOUNTS

THE tendency of those who have no honest intention to pay a just debt is to find or manufacture some excuses for not paying it. This tendency sometimes results in an entirely groundless suit or counterclaim against a physician on a charge of malpractice, where the physician resolutely seeks to enforce the rights that he has under the law to receive compensation for his services. That tendency may be recognized as a practical matter. But on the other hand, if it were to determine the usual course of physicians there is a likelihood of a custom growing up, among those reluctant to pay, of relying on the threat of a malpractice suit to prevent collection of physicians' accounts against them—and this of course should not be encouraged either. Physicians are peculiarly in that class of people who, in relation to their fees for services, can wisely follow the advice of the poet to "know their rights and knowing dare maintain."

There are a few legal principles which may not be too widely known but are of sufficient importance to be worth bringing to the attention of physicians for the purpose of refreshing their recollection, which will now be attempted to be done.

1. Physicians sometimes speak of fixing their own fees as if as a matter of right they may themselves fix the amount they can collect, and as if the amount fixed by them must necessarily be followed by the courts as the correct amount of the fee. This idea generally is erroneous. Physicians of course may agree with their patients in advance of rendering the services on the definite amount of the fee to be charged. Where an express contract is made in that manner and the services are rendered, the physician is entitled to collect the amount expressly agreed.

2. Where an express contract has not been made but the services have been rendered upon an implied contract, the physician has no more right to fix an arbitrary fee than the patient has. Both are parties to an implied contract under which the amount to be paid is a reasonable amount based upon the value of the services. There is no presumption which the law will indulge as to the value of the physician's service. The question of the value is one of fact which must be ascertained by the jury, if either party desires a jury trial, or by the judge if both parties waive the jury.

3. Some of the things which the trier of the fact, whether judge or jury, may consider in determining the reasonable value of the services are:

(a) Customary charges of physicians for like services in the same locality.

(b) The usual charge of the same physician and knowledge on the part of the patient of that usual charge.

(c) Previous charges made by the same physician to the same patient for similar treatment of members of the family of the patient.

(d) The amount of time actually devoted either to the giving of the treatment and to the research, including the study of books and articles, necessary for the proper diagnosis and treatment.

(e) Professional standing, skill and learning of the physician.

(f) Inconvenience and expense of the physician in connection with the rendering of the services.

4. Some of the things which are not considered by the trier of the facts are:

(a) The average daily income of the physician—for the physician cannot recover for the loss of business while away from his office and also for his compensation for the services unless by an express agreement.

(b) The financial condition of the patient, unless and until he has first furnished evidence of the existence of a custom in his community for physicians to graduate their charges on the basis of financial condition of the patients.

(c) The difficulty, if any, which the physician may have in collecting the account, nor the expense of such collection if it involves litigation or other expense.

5. In the proof of the value of the services, opinion or expert evidence may be given by physicians but not by others. Where the witnesses disagree, the trier of the facts may believe whom-ever he thinks worthy of belief and not believe those he thinks unworthy.

In view of the fact that the layman patient or other layman witnesses cannot express their opinions as to the value of the services, their testimony as to the value must be based upon matters of knowledge within their own experience. It cannot consist of evaluations based upon hypothetical questions.

An interesting feature of the law which permits the graduation of fees upon the basis of the ability to pay is that the courts have held that where a wealthy person employs a physician for a poor person as an act of generosity the physician cannot base the amount of his fee on the financial ability of that wealthy patron of the poor patient. The physician must charge the amount which he would charge if the patient were paying and not what he would charge if the services were being rendered for the wealthy person himself. Whatever concession might be made by a physician to a person in the same situation as the poor person would be the concession he must make even though the rich friend of the poor patient would be amply able to pay more.

It is not the part of wisdom for physicians, after the services have been rendered, to assume that it

is their duty or their right in all cases to stand upon the fee in the amount they themselves have fixed and sue the patient if he refuses to pay that amount willingly. Unless there is an express contract the amount is likely to be something of

a compromise anyhow. And sometimes it is better to effect a satisfactory compromise between the patient and the physician without going to court, than to have the awkward and unwelcome assistance of a jury.

MALPRACTICE

THE Year Books for 1947 and 1948 contain articles on this subject which might well be read again to refresh the recollection on the points covered in those articles. They will not be repeated in this article.

The newspapers and magazines have never before carried as many articles on medicine as are regularly appearing now. With the drives against cancer, tuberculosis, heart ailments, diabetes, polio, and for sight and hearing preservation, the public is bombarded from every side with scientific or pseudo-scientific information on medical questions. When they go to the physician they expect him to know at least everything they think they know, only to know it better and understand it more clearly.

Thus the general public with whom the medical profession deals is constantly setting up and revising its standards as to what physicians should do and be able to accomplish. Some of these standards have anticipated, probably by many years, the achievements which physicians may ultimately be able to accomplish. Out of this situation have developed some novel cases of alleged malpractice. They demonstrate the necessity of the physician keeping up with his profession, and using wisdom, tact and diplomacy in handling his patients so that they do not later stumble across something with which they may confront him, with the jubilant exclamation, "Aha, I have just found something that you did not do to me that you should have done, and for which I can now sue you unless you want to pay more quietly!"

There is a difficult distinction to be made between keeping right up to date in the treatment of a patient and experimenting with the patient. The doctor has the obligation to do the former and avoid the latter. That is all easy enough to say. But there may be serious difficulties in applying the rule.

For instance, a few years ago when malaria was first used as a treatment for syphilis, and some publicity had been given to it in the newspapers, a patient who was developing optic atrophy was diagnosed by a physician, and the physician recommended treatment for syphilis which did not include the malarial treatment. The patient lost

the sight of both eyes, and then sued the doctor on the ground that the doctor should have administered malarial treatment in the beginning but had failed to do so. The jury found for the defendant physician. The important element of defense was that the malarial treatment was still in an experimental stage. Suppose that the patient had been given the malarial treatment and had died from that treatment. Then the widow might have sued to collect damages for the wrongful death on the ground that the remedy had not been fully approved but was only in an experimental stage and had not been accepted generally by the profession. So the physician in this case might have been sued either for giving the treatment or for failing to give the treatment.

This may sound rather rough, but as a matter of practical fact there are very few cases where the doctor was found liable for damages in cases presenting such close questions.

A physician has no right to experiment with his patient unless he obtains the patient's consent. His duty is to follow an approved and recognized method of care and treatment. But a new type of treatment becomes approved and recognized only through experiment and the careful assembling of data and the logical deductions of generalizations from the data. If a person is given as fair and complete a statement of the facts regarding some experimental procedure as is within the power of the physician to give and the patient accepts voluntarily the suggested treatment, either as an experiment in the treatment of his own ailment or as an experiment in the development of medical science, the physician is not liable for unsatisfactory results. For such procedures the physician should have the consent of the patient or subject of experiment, and the consent should be given after the patient has been informed, as just stated, regarding the experiment. It is well to have such consent in writing with enough of the explanation and information regarding the experiment contained in the written consent to make clear and easily provable the truth of the situation, so that a change of mind later by the subject of the experiment cannot be a source of embarrassment to the physician.

REGULATION OF BARBERS

AN ACT was passed in 1933 for the regulation of barbers. The Act does not state its purpose but the Supreme Court of Indiana, in *State Board of Barber Examiners v. Cloud* (1942), 44 N.E. (2d) 972, declared that the Act was "clearly a sanitary measure."

The Act defines barbering as follows:

"Any one or any combination of the following practices, when performed upon the head, face and neck for cosmetic purposes and done for the public generally, either directly or indirectly, shall constitute the practice of barbering:

"Shaving or trimming the beard.

"Cutting hair."

"Giving facial and scalp massage or application of oils, creams, lotions or other preparations, either by hand or mechanical appliances.

"Singeing, shampooing or dyeing the hair or applying hair tonic.

"Applying cosmetic preparations, antiseptics, powders, oils, clays or lotions to scalp, face or neck.

"Provided, however, that such practices when done for the treatment of physical or mental ailments or disease shall not constitute barbering."

(Burns 1943 Replacement, Section 63-302.)

The statute requires graduation from an approved school of barbering as a condition of obtaining a license. The requisites of a barber school are stated in the statute as follows:

"No school of barbering shall be approved by the board unless it requires as a prerequisite to graduation a course of instruction of not less than one thousand (1,000) hours of continuous instruction of not more than eight (8) hours in any one (1) working day, such course of instruction to include the following subjects: Scientific fundamentals for barbering, hygiene and bacteriology; histology of the hair, skin, muscles and nerves; structure of the head, face and neck; elementary chemistry relating to sterilization and antiseptics; diseases of the skin, hair and glands; massaging and manipulating of the muscles; and cutting, shaving, arranging, dressing, coloring, bleaching and tinting of the hair."

(Burns 1943 Replacement, Section 63-303.)

The Act contains the following section regarding exemptions:

"The following persons are exempt from the provisions of this act while in the proper discharge of their professional duties:

"(1) Persons licensed by the law of this state to practice medicine and surgery, osteopathy or chiropractic.

"(2) Commissioned medical or surgical officers of the United States army, navy or marine hospital service.

"(3) Registered nurses.

"(4) Hairdressers and beauty culturists, in so far as their usual and ordinary vocation and profession is concerned, including light hair trimming incidental to waving of all kinds, which shall not include hair cutting.

"(5) Undertakers and morticians."

(Burns 1943 Replacement, Section 63-310.)

The barber law contains a section particularly directed toward hygiene and sanitation in connection with the practice of barbering. That section reads as follows:

"It shall be unlawful:

(a) For any barber or apprentice knowingly to continue the practice of barbering, or for any student knowingly to continue as a student in any school or college of barbering, while such person has an infectious, contagious or communicable disease.

(b) To own, manage, operate or control any barber shop or barber school unless continuously hot and cold running water be provided for therein, when same is available.

(c) To own, manage, operate or control any barber school or college, part or portion thereof, whether connected therewith or in a separate building, wherein the practice of barbering, as hereinbefore defined, is engaged in or carried on unless all entrances to the place wherein the practice of barbering is so engaged in or carried on shall display a sign indicating that the work therein is done by students exclusively.

(d) To own, manage, control or operate any barber shop, as hereinbefore defined, unless the same display a recognizable sign indicating that it is a barber shop, which said sign shall be clearly visible at the main entrance to said shop.

(e) To use a towel that is used on one (1) patron, on another patron unless the same has been laundered.

(f) Not to provide the head rest on each chair with a laundered towel or a sheet of clean paper for each patron.

(g) Not to place around the patron's neck a strip of cotton, towel or neck band so that the hair-cloth does not come in contact with the neck or skin of the patron's body.

(h) To use in the practice of barbering, as hereinbefore defined, any styptic pencils, finger bowls, sponges, lump alum or powder puffs. Possession of a styptic pencil, finger bowl, sponge, lump alum or powder puff in a barber

shop is *prima facie* evidence that the same is being used therein in the practice of barbering.

(i) To use on any patron any razors, scissors, tweezers, combs, rubber discs or parts or (of) vibrators used on another person, unless the same be kept in a closed compartment and immersed in boiling water, or in a solution of two (2) per cent carbolic acid, or its equivalent, for at least twenty minutes before use upon each client or customer.

"The state board of barber examiners shall have power to make other rules and regulations and prescribe other sanitary requirements in addition to the foregoing in aid or furtherance of the provisions of this act."

(Burns 1943 Replacement, Section 63-324.)

While the above excerpts from the Act dis-

close the recognition of the possibility of medical problems arising within the practice of barbering, the Legislature made no provision in this Act for a physician to be included on the board of Barber Examiners, as was done in the beauty culture law.

All laws such as these, the purposes of which are to improve sanitary and hygienic conditions, deserve the support and favorable attitude of the medical profession—and fortunately have always received that consideration from the medical profession. In the relations which the medical profession has with other occupations an excellent opportunity is afforded to establish the respect and friendship for the medical profession which is needed, not only for its own good, but also for the good of the general public so that scientific medicine and not quackery will be appealed to wherever actual medical needs arise.

BEAUTY CULTURISTS

IT IS sometimes difficult to draw a distinct line between the practice of one calling and the practice of another. The beauty culture law of 1935 contains some provisions which authorize beauty culturists to perform acts which could be classified as medical acts also. The statutory definition of the practice of medicine is as follows:

"To open an office for such purpose or to announce to the public in any way a readiness to practice medicine in any county of the state, or to prescribe for, or to give surgical assistance to, or to heal, cure or relieve, or to attempt to heal, cure or relieve those suffering from injury or deformity, or disease of mind or body, or to advertise, or to announce to the public in any manner a readiness or ability to heal, cure or relieve those who may be suffering from injury or deformity, or disease of mind or body, shall be to engage in the practice of medicine within the meaning of this act." (Burns 1943 Replacement, Section 63-1311.)

Attention is invited to that part of the definition which refers to healing, curing, or relieving those suffering from injury, deformity, or disease. The correction of a deformity, or the curing of a disease may be desired because of the cosmetic result.

The beauty culture law defines the practice of beauty culture as follows:

"Any one or any combination of the following practices when performed upon the head, face, neck, shoulders, arms and/or hands for cosmetic purposes and done for the public generally for pay or compensation shall constitute the practice of beauty culture:

"(1) Massaging, cleansing, stimulating, manipulating exercising or beautifying and/or

applying oils, creams, antiseptics, clays or lotions or other preparations either by hand or mechanical or electrical appliances.

"(2) To style, arrange, dress, curl, wave, permanent wave, cleanse, singe, bleach, dye, tint, color or similarly treat the hair of any person.

"(3) To cut, clip or trim the hair in combination with a permanent wave, and at no other time.

"(4) Arching eyebrows.

"(5) To remove superfluous hair from the face, shoulders or arms of any person by the use of an electric needle, herein referred to as electrolysis, or by the use of depilatories.

"(6) Cleansing, dressing or polishing the nails of any person or as herein referred to, as manicuring."

(Burns 1943 Replacement, Section 63-1802.)

The phrase in Sub-section (3) "and at no other time" is for the purpose of preventing the beauty culturist from infringing on the barbers' trade.

The use of an electric needle could be construed as within the field of surgery.

The word "beautifying" is not defined at all unless it might be defined by exclusion in the section above quoted. If an attempt were made to define it by exclusion, which would not be inconsistent with the rules of statutory construction, it could not consist of massaging, cleansing, stimulating, manipulating, exercising, or applying oils, creams, antiseptics, clays or lotions or other preparations either by hand or mechanical or electrical appliances. Neither could it include the acts listed under Sub-Section (2), (3), (4), (5) and (6). There would be no function performed by the word "beautifying" as used in the Act if beautifying

meant doing these other things. By strict grammatical construction it means doing something other than those which are mentioned in addition to beautifying. So the word "beautifying," if it means something besides the other acts mentioned, remains undefined.

Without regard, however, to the possible meaning of the word "beautifying," but accepting the definition of the practice of beauty culture as above stated and giving force and effect to it as fully as possible, there is in (1) provision for applying for cosmetic purposes oils, creams, antiseptics, clays, or lotions, or other preparations. It is difficult to draw a line between the performance of that kind of service for cosmetic purposes and of the kind of services rendered also for cosmetic purposes by the dermatologists. The fact that the beauty culturist confines her operations to the head, face, neck, shoulders, arms, and/or hands, does not make the problem easier.

No serious difficulties have developed out of this law so far as the effect upon the medical profession is concerned, but there have been some very serious developments as to the effect on the customer of the beauty culturist, particularly in regard to the use of the electrical appliances. Customers have been injured, and in some instances permanently, by their unskilled use.

Of course there is also the possibility of the customer not receiving early medical attention and diagnosis of diseases which he hopes to have corrected by the beauty culturist as something that presents only a cosmetic problem.

This article is not intended as an attack upon the beauty culture law nor as a criticism of beauty culturists. It is intended merely to point out how important it may be that the public understand that the intention of the law is to confine the work of the beauty culturists entirely to the performance of those services the purpose

of which is to improve the appearance of their customers—rather than to treat the customer for injury, disease, or deformity, which requires medical service for proper management and control.

The Legislature recognized the difficulty of establishing the dividing line between the practice of beauty culture and the practice of medicine in some instances, and also the necessity of medical knowledge being available in the administration of the beauty culture law. It made provision for a physician on the State Board of Beauty Culturists Examiners, which in effect is the administrative board that has the responsibility for the execution of the law. The members of the board consist of two who have been practicing beauty culturists for at least five years before their appointment, and a physician licensed to practice medicine in this state. A board thus constituted obviously makes more certain the accomplishment of the purposes of the Act which are declared in the Act to be "to prevent the spreading of diseases and promote the general health of the public by promoting sanitary conditions in beauty culture shops and beauty culture schools and in the practice of beauty culture."

So far as any information that has reached the headquarters of the Medical Association is concerned, there does not at this time seem to be any need for a further legislative attempt to limit and define beauty culture. It would be difficult to make a definition of beauty culture which did not include some elements that would have to be left to the good faith and common sense of those who administer the law and who practice under it.

The general absence of criticism of the operation of the law is evidence that both the administrators of the law and the beauty culturists have generally acted in a commendable manner in the discharge of their duties and the exercise of their privileges under the law.

AUGUST 31 IS REGISTRATION DEADLINE

Physicians are reminded that August 31 is the deadline for annual registration with the State Board of Medical Registration and Examination of Indiana, to escape paying a penalty and to prevent their certificates to practice from being automatically revoked.

The annual registration fee is \$5 for residents and \$10 for nonresidents of Indiana. A penalty of \$10 is assessed for failure to register before August 31. The board mailed notices to all doctors the last of June, but if you did not receive one, mail your registration fee to the board, 1138 K. of P. Building, Indianapolis 4. Personal checks will be accepted.

PRIVILEGED COMMUNICATIONS AND RIGHT OF PRIVACY

A SHORT article on privileged communications was published in the 1947 Indiana Medical Year Book, which was THE JOURNAL of the association for January of that year. Since publication of that article, a case involving a closely related right was filed in Indiana which was carried to the Appellate and Supreme Courts of the state. The final decision was written by the Appellate Court and is reported in 78 N. E. (2d) page 789. A petition to transfer to the Supreme Court was denied by the Supreme Court. That case involved the right of privacy which is recognized as a common law right. The following is a summary of the facts in the case:

A physician employed a collection firm to collect an account for professional services. In its efforts to collect the account the collection agency wrote to the patient's employer informing the employer that the patient owed the doctor \$65.00. Later the doctor also wrote a statement regarding the debt which was mailed to the patient's employer. The patient then sued the doctor, claiming \$3,000 damages as a result of "mental pain, anguish and humiliation" she suffered from having her employer informed of the fact that she owed a doctor bill.

The case was not tried on the theory that either slander or libel were involved. The truth would have been a defense against such an action. Neither was it tried on the ground that any confidential relationship, such as the law recognizes as between physician and patient, was violated. Against an action of that kind a successful defense could have been made on the ground that what pertains to the collection of an account and does not pertain to the professional services themselves and the physical condition of the patient, is not within the confidential relationship.

The theory of the action was that the patient had a right of privacy with respect to business matters that affected only herself and her creditor, and that the creditor violated that right of privacy by telling the employer of the debt she owed. The court held that while a general publication to the extent that the fact of the debt became general public information could constitute a violation of

the right of privacy, there was no invasion of that right "solely in the fact that the appellees, (the physician and collection agency), in an effort to collect a bill, brought the matter to the attention of the appellant's (the patient's) employer in which the employer's aid was solicited and the facts and circumstances of the indebtedness were detailed" did not constitute a violation of her right of privacy.

In the course of the opinion the court comments upon the distinction between this case and those in which the creditor "gave the general public information concerning a private matter in which it had, or could have, no legitimate interest, and did so in a manner that was coercive and oppressive." The court pointed out that the employer could have an interest in whether his employee owed debts with respect to which the employer might be made a garnishee defendant or be otherwise involved in an attempt of the creditor to collect the debt.

This case is brought to the attention of the profession as illustrative of the right of privacy which is a right similar to the right of confidential relationship, but different from it in the fact that it is not a right that exists only because one is a physician and the other a layman.

The cases in which actions were successfully prosecuted for violation of the right of privacy may be illustrated by the Kentucky case (*Brents v. Morgan*, 221 Ky. 765, 299 S. W. 967), where the creditor posted a notice 5 ft. x 8 ft. announcing that the debtor owed him \$49.67, and stating, "and if promises would pay an account this account would have been settled long ago. This account will be advertised as long as it remains unpaid"; and in the cases where letters or other publicity were sent to neighbors and friends of the alleged debtor informing them of the alleged debt.

The violation of a right of privacy, it will be seen from this discussion, occurs where one's private affairs are aired before people who have no interest or right with respect to which the information can be of any value. The right of privacy is not violated where one gives information to a person who has a definite interest in receiving the information for his own protection.



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Angola				Evansville			
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	Elmhurst Hospital, Inc.	Gen.	21		Protestant Deaconess Hospital ----	Gen.	242
Argos					St. Mary's Hospital, Inc. -----	Gen.	186
	Kelly Hospital, Inc. -----	Gen.	10		Welborn Memorial Baptist Hos- pital, Inc. -----	Gen.	128
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Beech Grove					Clinton County Hospital -----	Gen.	43
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Bloomington					Johnson County Memorial Hos- pital -----	Gen.	68
	Bloomington Hospital -----	Gen.	75	Garrett			
Bluffton					Sacred Heart Hospital -----	Gen.	42
	Caylor-Nickel Hospital, Inc. -----	Gen.	75	Gary			
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Columbia City					Decatur County Memorial Hos- pital -----	Gen.	50
	Memorial Hospital -----	Gen.	20	Hammond			
Columbus					St. Margaret Hospital -----	Gen.	260
	Bartholomew County Hospital ----	Gen.	75	Hartford City			
Connersville					Blackford County Hospital -----	Gen.	32
	Fayette Memorial Hospital -----	Gen.	42	Huntingburg			
Crawfordsville					The Stork Hospital -----	Gen.	27
	Montgomery County Culver Union Hospital -----	Gen.	85	Huntington			
Crown Point					Huntington County Hospital -----	Gen.	50
	James O. Parramore Hospital ----	T.B.	235	Indianapolis			
Decatur					Indianapolis General Hospital ---	Gen.	704
	Adams County Memorial Hospital -	Gen.	48		(Includes Flower Mission)		
Dyer					Indiana University Medical Center (James Whitcomb Riley Hospital for Children -----	Gen.	127
	Mount Mercy Sanitarium -----	Spec. (Gen.) (N.&M.)	75		Robert W. Long Hospital -----	Gen.	251
East Chicago					William H. Coleman Hospital for Women) -----	Spec.	72
	St. Catherine Hospital -----	Gen.	264				
Elkhart							
	Elkhart General Hospital -----	Gen.	111				

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

City	Name	Type	Beds	City	Name	Type	Beds
Methodist Hospital of Indiana, Inc.	Public Health Center	Gen.	639	New Castle	The Clinic	Gen.	22
		Spec.	110	Henry County Hospital		Gen.	110
		V. D.		Noblesville			
		Gen.	329	Hamilton County Hospital		Gen.	48
		T.B.	224	Oakland City			
St. Vincent's Hospital	Sunnyside Sanatorium	Gen.	329	Wood Hospital and Clinic		Gen.	12
		T.B.	224	Paoli			
		Spec.	18	Clark Hospital, Inc.		Gen.	11
St. Elizabeth Maternity Hospital and Infant Home	Suemma Coleman Home	(Mat.)		Peru			
		Spec.	32	Dukes - Miami County Memorial Hospital		Gen.	64
		(Mat.)		Wabash Employees Hospital Association		Gen.	50
Jeffersonville				Plymouth			
Clark County Memorial Hospital		Gen.	91	Parkview Hospital		Gen.	33
Kendallville				Portland			
McCray Memorial Hospital		Gen.	32	Jay County Hospital		Gen.	35
Kokomo				Princeton			
St. Joseph Memorial Hospital		Gen.	125	Gibson General Hospital		Gen.	44
Lafayette				Rensselaer			
Lafayette Home Hospital		Gen.	135	Jasper County Hospital		Gen.	40
St. Elizabeth Hospital		Gen.	305	Richmond			
William Ross Sanatorium		T.B.	27	Reid Memorial Hospital		Gen.	150
La Grange				Smith-Esteb Memorial Hospital		T.B.	47
La Grange County Hospital		Gen.	14	Rochester			
La Porte				Woodlawn Hospital		Gen.	32
Fairview Hospital Association, Inc.		Gen.	72	Rockville			
Holy Family Hospital		Gen.	98	Indiana State Sanatorium		T.B.	200
Lebanon				Rome City			
Witham Memorial Hospital		Gen.	70	Kneipp Springs Sanatorium		Spec.	150
Linton				(Chronic)			
Freeman-Greene County Hospital		Gen.	50	Rushville			
Logansport				Rushville City Hospital		Gen.	14
Memorial Hospital		Gen.	70	Scottsburg			
St. Joseph Hospital		Gen.	60	Napper Hospital		Gen.	11
Madison				Seymour			
King's Daughters' Hospital		Gen.	48	Jackson County Schneck Memorial Hospital		Gen.	56
Marion				Shelbyville			
Marion General Hospital		Gen.	105	William S. Major Hospital		Gen.	49
Martinsville				South Bend			
Morgan County Memorial Hospital		Gen.	28	Healthwin Hospital		T.B.	119
Michigan City				Memorial Hospital of South Bend		Gen.	220
The Clinic Hospital		Gen.	50	St. Joseph's Hospital		Gen.	184
St. Anthony Hospital		Gen.	100	South Bend Osteopathic Hospital		Gen.	24
Warren Hospital, Inc.		Gen.	17	Sullivan			
Milan				Mary Sherman Hospital		Gen.	50
The Whitlatch Clinic and Hospital, Inc.		Gen.	24	Tell City			
Mishawaka				Parkview Hospital		Gen.	11
St. Joseph Hospital		Gen.	84	Terre Haute			
Mooresville				Florence Crittenton Home		Spec.	3
Comer Sanitarium		Spec.	21	(Mat.)			
Muncie				Hoover Sanatorium		Gen.	14
Ball Memorial Hospital		Gen.	217	St. Anthony Hospital		Gen.	185
New Albany				Union Hospital		Gen.	182
St. Edward Hospital		Gen.	100				
Silvercrest (Southern Indiana Tuberculosis Hospital)		T.B.	152				

City	Name	Type	Beds	City	Name	Type	Beds
Tipton				Warsaw			
	Emergency Hospital -----	Gen.	10		McDonald Hospital -----	Gen.	40
					Murphy Medical Center -----	Gen.	35
Union City				Washington			
	Union City Hospital, Inc. -----	Gen.	13		Daviess County Hospital -----	Gen.	105
Valparaiso				Williamsport			
	Porter Memorial Hospital -----	Gen.	67		Community Hospital -----	Gen.	20
Vincennes				Winamac			
	Good Samaritan Hospital -----	Gen.	115		Carneal's Private Hospital -----	Gen.	7
	Hillcrest Tuberculosis Hospital ---	T.B.	60	Winchester			
					Randolph County Hospital -----	Gen.	37
Wabash				Wolf Lake			
	Wabash County Hospital -----	Gen.	60		Luckey Hospital -----	Gen.	20

ACCREDITED SCHOOLS OF NURSING IN INDIANA

School of Nursing and Hospital, University or College with which School is Connected	Location	Director, School of Nursing	Daily Patient Census
a St. John's Hickey Memorial -----	Anderson	Sister M. Celeste, R.N.-----	227
St. Catherine -----	East Chicago	Miss Marie E. Hickey, R.N.-----	300
Protestant Deaconess -----	Evansville	Miss Thelma Brittingham, R.N.-----	216
St. Mary's -----	Evansville	Sister Georgiana, R.N.-----	153
Welborn Memorial Baptist -----	Evansville	Mrs. Madeline T. Kinney, R.N.-----	98
a Lutheran -----	Fort Wayne	Miss Pauline G. Bischoff, R.N.-----	216
Methodist -----	Fort Wayne	Miss Marie Kolter, R.N.-----	129
St. Joseph's -----	Fort Wayne	Miss Verne Pattee, R.N.-----	300
Methodist -----	Gary	Miss Emily Stockford, R.N.-----	224
St. Mary Mercy -----	Gary	Sister M. Vitalis, R.N.-----	219
St. Margaret -----	Hammond	Sister M. Florianne, R.N.-----	242
a St. Mary's College—affiliated with Mt. Carmel Hospital (Degree Program)-----	Holy Cross Columbus, O.	Sister M. Amadeo, R.N.-----	286
Indiana University Training School for Nurses—Indiana University Medical Center --	Indianapolis	Miss Jean Coffey, R.N., Actg.-----	536
a Indianapolis General -----	Indianapolis	Miss Elizabeth C. Wivel, R.N.-----	576
Methodist -----	Indianapolis	Miss E. Louise Grant, R.N.-----	615
St. Vincent's -----	Indianapolis	Sister Delphine, R. N. -----	365
a Good Samaritan School—St. Joseph Memorial Hospital -----	Kokomo	Sister M. Bernadette, R.N.-----	141
LaFayette Home -----	LaFayette	Miss Lucille H. Johnson, R.N.-----	127
St. Elizabeth -----	LaFayette	Sister M. Florina, R.N.-----	226
St. Joseph's -----	Mishawaka	Miss Madelin C. Coleman, R.N.-----	90
Ball Memorial -----	Muncie	Miss Margaret I. Boal, R.N.-----	246
Reid Memorial -----	Richmond	Miss Prudence Appleman, R.N.-----	138
Memorial Hospital of South Bend -----	South Bend	Miss Elsie Norman, R.N.-----	208
a St. Joseph -----	South Bend	Sister M. Clare Anne, R.N.-----	190
St. Anthony -----	Terre Haute	Sister Mary Nora, R.N.-----	159
Union -----	Terre Haute	Miss Emily Gifford, R.N.-----	174
Good Samaritan -----	Vincennes	Mrs. Zilpha M. Burnett, R.N.-----	110

a—Negro students are enrolled

PRIVATE NURSING HOMES IN INDIANA*

ALLEN COUNTY

Colonial Nursing Home
802 W. Berry St., Ft. Wayne
Miss Inez Gross, R.N.
License expires 4-19-50

The Crater Nursing Home
1407 E. Wayne St., Ft. Wayne
Mrs. Pearl Crater
License expires 10-11-49

Lawton Place Nursing Home
1649 Spy Run Ave., Ft. Wayne
Walter C. Buuck
License expires 4-28-50

Twin Maples Sanitarium
734 W. Wash. Blvd., Ft. Wayne
Mrs. Gladys Pavey
License expires 10-27-49

Yerrick Home for Men
516 W. 3rd St., Ft. Wayne
Mrs. Gladys Yerrick
License expires 10-27-48

BARTHOLOMEW COUNTY

Brown Nursing Home
318 South St., Box 87, E. Columbus
Ithamer Brown
License expires 11-15-49

Columbus Nursing Home
213 4th St., Columbus
Robert E. Lee
License expires 4-16-50

Redman's Sanitarium
R. R. 4, Columbus
Frank A. & Nellie D. Redman
License expires 7-6-49

BLACKFORD COUNTY

Whitacre Nursing Home
428 W. Huntington St., Montpelier
William H. Whitacre
License expires 8-23-49

BOONE COUNTY

Cora's Nursing Home
121-123 S. East St., Lebanon
Mrs. Cora Nelson
License expires 4-13-50

Schwinn Nursing Home
214 S. Pearl St., Thorntown
Mrs. Pansy Schwinn
License expires 3-29-50

Trammel Nursing Home
415 N. Clark St., Lebanon
Mrs. Sarah S. Trammel
License expires 2-7-50

CARROLL COUNTY

The Arzula Flora Nursing Home
312 W. Main St., Flora
Miss Ida Arzula, Flora
License expires 3-16-50

Mamie Kennedy Nursing Home
404 S. Center St., Flora
Mrs. Mamie J. Kennedy
License Expires 4-11-50

Porter Nursing Home
616 E. Monroe St., Delphi
Mrs. Alsie J. Porter
License expires 12-30-49

CASS COUNTY

Galveston Nursing Home
Washington & Sycamore Sts., Galveston
Estie & Ednabelle Bell
License expires 7-1-49

Huffman Nursing Home
2533 Broadway, Logansport
Mrs. Honour R. Huffman
License expires 3-5-50

Justice Nursing Home
227 Cliff Dr., Logansport
Mr. & Mrs. Martin Justice
License expires 5-7-50

Rest Haven Nursing Home
731 North St., Logansport
Miss Olive S. Jones
License expires 4-18-50

Van Winkle Nursing Cottage
421 15th St., Logansport
Mrs. Ruth S. Van Winkle
License expires 3-2-50

CLARK COUNTY

Keller Home
403 E. 7th St., Jeffersonville
Mrs. Florence Keller
License expires 7-30-49

CLINTON COUNTY

McKinsey Nursing Home
407 E. Walnut St., Frankfort
Mrs. Jane McKinsey
License expires 5-24-49

Harriet Ann Stoker's Nursing Home
R. R. 4, Frankfort
Mrs. Harriett Ann Stoker
License expires 1-20-50

DECATUR COUNTY

Davis Nursing Home
510 W. Wash. St., Greensburg
Mrs. Edith A. Davis
License expires 9-7-49

Michigan Hills Nursing Home
320 S. Michigan Ave., Greensburg
Mrs. Mary L. Mobley
License expires 5-13-50

DEKALB COUNTY

Brouse Nursing Home
R. R. 2, Butler
W. H. & Susie M. Brouse
License expires 4-28-50

Williams Convalescent Home
402 N. Broadway St., Butler
Mrs. Pauline & R. E. Williams
License expires 3-23-50

DELAWARE COUNTY

Karcher Home
Selma
Mrs. Aida Karcher
License expires 1-19-50

Sylvester Home for the Aged
Burlington Dr., Muncie
Mrs. Nellie Sylvester
License expires 7-1-49

Williams Nursing Home
1525 S. Monroe St., Muncie
Mrs. Rena Williams
License expires 9-20-49

Woodland Home
917 E. Main St., Muncie
Mrs. Hazel Wilson
License expires 8-28-49

* Licensed for One year by the State Department of Public Welfare—List Compiled May 13, 1949.

ELKHART COUNTY

The Austin Home
526 N. 6th St., Goshen
Mr. & Mrs. Fred S. Austin
License expires 12-22-49

Coil's Convalescent Home
225 S. 5th St., Goshen
Mrs. Wilma Louise Coil
License expires 8-9-49

The Herrli Home
318 E. Beardsley Ave., Elkhart
Mrs. Nellie M. Herrli
License expires 3-10-50

Holm Convalescent Home
807 N. Main St., Goshen
Mrs. Goldie Holm
License expires 4-28-50

Lockerbie Nursing Home
302 E. Lincoln Ave., Goshen
Mrs. Bertha J. K. Lockerbie
License expires 6-24-49

Schieber Convalescent Home
R. R. 2, Bristol
Mrs. Lulu Schieber
License expires 8-31-48

FRANKLIN COUNTY

Brookside Nursing Home
R. R. 5, Brookville
Ida Ruth & Chester C. O'Neal
License expires 11-26-49

The Resthaven Reifel Nursing Home
1015 Franklin St., Brookville
Mrs. Elizabeth A. Reifel
License expires 6-26-49

FULTON COUNTY

Ewing Nursing Home
719 Madison St., Rochester
Ernest Baxter
License expires 1-20-50

GIBSON COUNTY

Church Convalescent Home
417 W. Broadway, Princeton
Mrs. Edra E. Church
License expires 5-19-49

GRANT COUNTY

Bide-A-Wee Rest Home
910 N. Rush St., Fairmount
Mrs. Agnes Butcher
License expires 8-26-49

Darr's Convalescent Home
702 E. 26th St., Marion
Mrs. Maude L. Darr
License expires 3-30-50

HAMILTON COUNTY

Arcadia Rest Home
P. O. Box 215, Arcadia
Mrs. Florence Sigler
License expires 8-23-49

Moore's Nursing Home
South St., Arcadia
Mrs. Maxine Moore,
License expires 12-30-49

HANCOCK COUNTY

Haney's Nursing Home
114 E. North St., Greenfield
Ila B. Haney
License expires 8-10-49

The Siders Home
124 E. Osage St., Greenfield
Mrs. Elizabeth Siders
License expires 5-19-49

Wood's Nursing Home
14 N. Wood St., Greenfield
Mrs. Hazel E. Wood
License expires 5-19-49

HENDRICKS COUNTY

Franklin Nursing Home
Clayton
Mrs. Sarah E. Franklin
License expires 4-29-50

Plainfield Nursing Home
404 Vine St., Plainfield
Miss Lois B. Thompson
License expires 1-7-50

HOWARD COUNTY

Martin's Old Age Home
929 N. Main St., Kokomo
Mrs. Myrtle E. Martin
License expires 9-8-49

Restmor Nursing Home
420 N. Market, Kokomo
Lyman A. & Rose Thatcher
License expires 1-7-50

HUNTINGTON COUNTY

Davis Nursing Home
207 Frederick St., Huntington
Mrs. Annette Davis
License expires 8-2-49

DeKoning Convalescent Home
R. R. 8, Huntington
Mrs. Ann Cecilia DeKoning
License expires 2-10-50

Jefferson Sanitarium
414 S. Jefferson St., Huntington
Herbert Earl Atkinson, Sr.
License expires 2-28-50

Oak Park Nursing Home
743 N. Main St., Roanoke
Mrs. Fern N. Martin
License expires 6-24-49

Sears Nursing Home
325 S. Jefferson, Huntington
Mrs. Ethel K. Sears
License expires 12-15-49

JACKSON COUNTY

Roselawn Nursing Home
609 E. 6th St., Seymour
Mrs. Esta T. Martin
License expires 3-24-50

JOHNSON COUNTY

Johnson Nursing Home
651 S. State St., Franklin
Mrs. Janie Johnson
License expires 1-11-50

McKee's Nursing Home
400 Kentucky St., Franklin
Mrs. Florence Ellen McKee
License expires 7-20-49

KOSCIUSKO COUNTY

Alfran Nursing Home
R. R. 1, Rd. 30, Pierceton
Mrs. Alice M. Wilson, R.N.
License expires 11-16-49

Armington Home
519 W. Winona Ave., Warsaw
Mrs. Charles Armington
License expires 9-21-49

LAGRANGE COUNTY

Stowe Home for the Aged
412 N. Walnut St., LaGrange
Mrs. Hattie B. Stowe
License expires 5-24-49

LAKE COUNTY

Laura Beaton Nursing Home
521 Pennsylvania St., Gary
Mrs. Laura Beaton
License expires 4-15-50

Calloway's Nursing Home (Col.)
1948 Massachusetts St., Gary
Mrs. Tomye Calloway
License expires 2-28-50

Green's Home for Aged
3960 Massachusetts St., Gary
Mrs. Lillian Green
License expires 6-24-49

Hill Top Nursing Home
R. R. 2, Crown Point
Mrs. Olive Beggs
License expires 5-29-49

Miller's Nursing Home (Col.)
2301 Adams St., Gary
Miss Ida Miller
License expires 4-8-50

Sanders Nursing Home (Col.)
1944 Maryland St., Gary
Mrs. LaGora Sanders
License expires 5-5-50

LAWRENCE COUNTY

The Greenwell Home
329 W. Oak St., Mitchell
Mrs. Florence Greenwell
License expires 8-9-49

Kinder Nursing Home
618 "I" St., Bedford
Mrs. Mabel M. Kinder
License expires 9-27-49

Stancombe Nursing Home
R. R. 5, Bedford
Clifford & Pearl Stancombe
License expires 2-4-50

MADISON COUNTY

Bright Memorial Home
2025 Jackson St., Anderson
Mrs. Blanche Graser
License expires 2-10-50

Brown's Nursing Home
508 W. 3rd St., Anderson
Mrs. Lillian May Brown
License expires 11-16-49

James Nursing Home
722 W. 5th St., Anderson
Mrs. Hazel James
License expires 12-20-49

Rahbek Nursing Home No. 1
1102 E. 6th St., Anderson
Mrs. Marie Livingston Rahbek
License expires 9-13-49

Rahbek Nursing Home No. 2
528 Walnut St., Anderson
Mrs. Marie Livingston Rahbek
License expires 6-24-49

Van Dyke Nursing Home
2417 Pearl St., Anderson
Mrs. Pearl M. Van Dyke
License expires 3-16-50

MARION COUNTY

Albrecht's Convalescent Home
1814 N. New Jersey St., Indianapolis
Mrs. Gertrude Keller Albrecht
License expires 4-22-50

Anselm Nursing Home
702-704 N. Alabama St., Indianapolis
Mrs. Ada Anselm
License expires 3-11-50

Conde Nursing Home
624 E. 12th St., Indianapolis
Marion Niles & Beulah Gronlund
License expires 11-22-49

Fletch-Haven Sanitarium
732 Fletcher Ave., Indianapolis
Garald Wayne Starr
License expires 6-1-49

Francis Nursing Home
604 N. Jefferson Ave., Indianapolis
Mrs. Mattie B. Francis
License expires 7-24-49

Hall Haven Rest Home
2223 Churchman Ave., Indianapolis
Mrs. Carrie M. Hall
License expires 8-17-49

Higgins Nursing Home
1336 Bellefontaine St., Indianapolis
Mrs. Mollie Higgins
License expires 2-17-50

Huff's Sanitarium
115 S. Audubon Rd., Indianapolis
Gertrude & Herman Huff
License expires 5-6-50

Irrington Nursing Home
R. R. 10, Box 320, Indianapolis
Mrs. Minnie P. Waymire
License expires 7-7-49

King Nursing Home
1907 N. Illinois St., Indianapolis
Mrs. Princie King
License expires 11-26-49

Myrtle Lee Nursing Home
1429 Carrollton Ave., Indianapolis
Miss Mabel Cecilia Smalley
License expires 5-16-50

Lynhurst Nursing Home
5225 W. Morris St., Indianapolis
Thomas E. & Barbaraella K. Brown
License expires 4-8-50

Martin Nursing Home
2037 N. Illinois St., Indianapolis
Mrs. Beulah Martin
License expires 3-8-50

Mary Messer Nursing Home
1336 N. Delaware St., Indianapolis
Mrs. Mary J. Messer
License expires 11-26-49

Olympia Nursing Home
6879 E. Washington, Indianapolis
Mrs. Frances Limpus
License expires 8-8-49

Rest Haven Sanitarium
3245 N. Illinois St., Indianapolis
Mrs. Carolyn E. Carden
License expires 6-9-49

Robinson's Home
2250 Central Ave., Indianapolis
Mrs. Eunice Robinson
License expires 7-14-49

Robinson's Private Home
2254 Central Ave., Indianapolis
Mrs. Eunice Robinson
License expires 7-14-49

The Roethig Home
350 Villa Ave., Indianapolis
Mrs. Anna Roethig
License expires 6-3-49

Rose Lawn Home
2835 N. Meridian St., Indianapolis
Mrs. Lucy V. Conner
License expires 5-5-50

Suddarth Nursing Home
1445 Broadway, Indianapolis
Mrs. Cleo Suddarth
License expires 5-7-49

Vollmer Convalescent Home
2630 College Ave., Indianapolis
Mr. Emory H. Vollmer
License expires 6-24-49

Mrs. Waddle's Private Home
2112 N. Delaware St., Indianapolis
Mrs. Mable S. Waddle
License expires 8-25-49

Wagner Nursing Home
2021 N. Meridian St., Indianapolis
Mrs. Florence Wagner
License expires 8-6-49

Ward Nursing Home (Colored)
1518 N. Senate, Indianapolis
Mrs. Willa Mae Murray Anderson
License expires 5-19-49

Warman Avenue Rest Home
46 S. Warman Ave., Indianapolis
Miss Mary Elizabeth Holland
License expires 8-30-49

Weber Convalescent Home
43 S. Ritter Ave., Indianapolis
Mrs. Laura E. Weber
License expires 4-23-50

West Park Home
373 N. Holmes Ave., Indianapolis
Mrs. Mary R. Frame
License expires 6-18-49

Wildwood Restorium
895 Middle Drive, Woodruff
Place, Indianapolis
Mrs. Nellie Wildman
License expires 1-7-50

MARSHALL COUNTY

Austin Nursing Home
821 Angell St., Plymouth
Mrs. Mabel M. Austin
License expires 9-23-49

Bair Convalescent Home
N. Main St., Bourbon
Mrs. Kathryn M. Bair, R.N.
License expires 8-6-49

Sherman Nursing Home
203 Pennsylvania Ave., Plymouth
Mrs. Vesta K. Sherman
License expires 10-18-49

MIAMI COUNTY

Glen Rest Convalescent Home
R. R. No. 4, Peru
Mrs. Thelma Woeckener
License expires 6-18-49

Peru Nursing Home
906 W. Main St., Peru
Mrs. Marie A. Donat
License expires 3-12-50

MONROE COUNTY

Hazel's Nursing Home
1031 W. 6th St., Bloomington
Mrs. Ona B. Hazel
License expires 11-26-49

Henry Home
421 W. 1st St., Bloomington
Mrs. Gertie Henry
License expires 2-11-50

Myrtle Percifield Nursing Home
705 W. 4th St., Bloomington
Mrs. Myrtle Percifield
License expires 6-24-49

Wilkins Nursing Home No. 1
1023 E. 10th St., Bloomington
Mrs. Orpha A. Wilkins
License expires 3-29-50

Wilkins Nursing Home No. 2
601 N. Walnut Grove, Bloomington
Mrs. Orpha A. Wilkins
License expires 3-29-50

MONTGOMERY COUNTY

Hart Memorial Home
R. R. No. 1, Crawfordsville
Mrs. Myrtle Johnson
License expires 4-14-50

Maxwell Nursing Home
1805 E. Fremont St., Crawfordsville
Mrs. Godey Maxwell Graves
License expires 7-14-49

OHIO COUNTY

Calbreath Home
4th St., Rising Sun
Mrs. Effie Galbreath
License expires 3-31-50

OWEN COUNTY

Gosport Nursing Home
W. Main St., Gosport
Mrs. Annis T. Martin
License expires 6-28-49

PIKE COUNTY

Moore's Nursing Home
409 W. Walnut St., Petersburg
Mrs. Adaline Bernice Moore
License expires 5-24-49

Riddle Nursing Home
411 Walnut St., Petersburg
Mrs. Alice M. Riddle

PORTER COUNTY

Woods Home
R. R. No. 2, W. Dunes Highway,
Michigan City
Mrs. Helen O. Wood
License expires 2-9-50

PUTNAM COUNTY

Westfall Nursing Home
218 Bloomington St., Greencastle
Mrs. Nina A. Westfall
License expires 11-26-49

RUSH COUNTY

Clark Boarding and Nursing
Home
230 E. 7th St., Rushville
Mr. and Mrs. Harry Clark
License expires 1-20-50

Clifton Nursing Home
204 W. 3rd St., Rushville
Mrs. Mary Clifton
License expires 9-29-49

Jackson Nursing Home
413 N. Morgan St., Rushville
Mrs. Goldie C. Jackson
License expires 9-14-49

SCOTT COUNTY

Shuell Nursing Home No. 1
R. R. No. 1, Scottsburg
Mrs. Ella L. Shuell, R.N.
License expires 5-7-50

Shuell Nursing Home No. 2
R. R. No. 1, Scottsburg
Mrs. Ella L. Shuell, R.N.
License expires 5-7-50

SHELBY COUNTY

The Maples
R. R. No. 1, Fountaintown
Mr. and Mrs. William McGraw
License expires 10-23-49

SPENCER COUNTY

Mayhall Nursing Home
417 S. 6th St., Rockport
Mrs. Alice Mayhall
License expires 10-29-49

STARKE COUNTY

Ruff Nursing Home
W. John St., Knox
Mrs. Alcinda Ruff
License expires 8-7-49

ST. JOSEPH COUNTY

Branchflower Nursing Home
1217 S. Michigan St., South
Bend
Mrs. Maggie R. Branchflower
License expires 7-21-49

Copenhaver Home
914 W. 4th St., Mishawaka
Mrs. June Copenhaver
License expires 4-29-50

Emerick Home for the Aged
910 W. 4th St., Mishawaka
Mrs. Ila Mae Emerick
License expires 9-1-49

Jones Nursing Home
702 S. Columbia St., South Bend
Mrs. Vera Jones
License expires 10-18-49

Kintz's Rest Home
1527 South Bend Ave., South Bend
Mrs. Edith Kintz
License expires 9-23-49

Krogh Nursing Home
109 N. Cedar St., Mishawaka
Miss Bernalda I. Krogh
License expires 4-29-50

Williams Nursing Home No. 1
601 N. Main St., South Bend
Mrs. Alma Williams
License expires 7-13-49

Williams Nursing Home No. 2
1145 Napier St., South Bend
Mrs. Alma Williams
License expires 11-4-49

TIPPECANOE COUNTY

Burnett Convalescent Home
221 S. 9th St., Lafayette
Mrs. Angie Burnett
License expires 4-4-50

Mackey Nursing Home
641 New York St., Lafayette
Mrs. Betty Mackey Lewis
License expires 11-4-49

Scott Nursing Home for Men
614 N. 8th St., Lafayette
Howard F. Scott
License expires 8-9-49

Scott Nursing Home for Women
1100 N. 9th St., Lafayette
Mrs. Goldie Scott
License expires 11-26-49

UNION COUNTY

Anna Scott Nursing Home
302 W. Union St., Liberty
Mrs. Anna Scott
License expires 5-12-50

VANDEBURGH COUNTY

Bethany Rest Home
316 N. Wabash Ave., Evansville
Mrs. Claudia Edith Poole
License expires 5-14-49

Comfort Rest Home
811 S.E. 3rd St., Evansville
Mrs. Ethel B. Drake
License expires 10-14-49

Anna Evans Nursing Home
(Colored)
605 Oak St., Evansville
Mrs. Anna Evans
License expires 1-27-50

Gish's Rest Home
923 S. Elliott St., Evansville
Mrs. Ethel G. Gish
License expires 9-24-49

Jarrett's Convalescent Home
605 Oakley St., Evansville
Mrs. Lena K. Jarrett
License expires 6-30-49

The Maxey Nursing Home
36 W. Illinois St., Evansville
Mrs. Marie Maxey
License expires 8-25-49

Pickett and Floyd Boarding Home
200-202 W. Illinois St., Evansville
Wm. J. Pickett and Laura Floyd
License expires 10-27-49

Rest Haven Home
807 S.E. 3rd St., Evansville
Mrs. Dorothy Wolf Tindall
License expires 10-14-49

Singleton Nursing Home
909 1st Ave., Evansville
Mrs. Fern Singleton
License expires 6-2-49

Ingle Smith Home
521 S. 1st St., Evansville
Mrs. Della Ingle Smith, R.N.
License expires 6-26-49

Taylor Nursing Home
915 W. Bond St., Evansville
Mrs. Juanita Taylor
License expires 5-24-49

Ulbricht Rest Home
616 W. Franklin St., Evansville
Mrs. Martha Ulbricht
License expires 2-21-50

VIGO COUNTY

Cook Nursing Home
2058 N. 7th St., Terre Haute
Mrs. Grace E. Cook
License expires 6-2-49

Lydia E. Foos Home
418 S. 8th St., Terre Haute
Mrs. Lydia E. Foos
License expires 7-21-49

Gano Nursing Home
501 N. 4th St., Terre Haute
Mrs. Anna Gano
License expires 4-8-50
Hise Nursing Home
120 N. 12th St., Terre Haute
Mrs. Lillie Hise
License expires 3-21-50
Kesler's Nursing Home
724 N. 8th St., Terre Haute
Mrs. Clara A. Kesler
License expires 8-19-49
Doris Standeford Nursing Home
1103 S. 11½ St., Terre Haute
Miss Doris Standeford
License expires 3-16-50
Sullivan Nursing Home
705 S. 7th St., Terre Haute
Mrs. Grace F. Sullivan
License expires 12-30-49

WABASH COUNTY

Moss Nursing Home
855 Ferry St., Wabash
Mrs. Irene Moss
License expires 8-28-49
Sincroft Nursing Home
306 E. 4th St., North Manchester
Mrs. Pearl Sincroft
License expires 1-21-50

WAYNE COUNTY

Bowman's Rest Home
444 W. Main St., Cambridge City
Howard and Esther Bowman
License expires 3-16-50
Gains Nursing Home
R. R. No. 2, Box 448, Richmond
Mrs. Emma Gains
License expires 1-5-50
Grey Gables Nursing Home
R. R. No. 1, Centerville
Mrs. Hazel C. Wadie
License expires 8-10-49

WELLS COUNTY

Davis Convalescent Home
627 S. Marion St., Bluffton
Mrs. Helen Davis
License expires 4-11-50

WHITLEY COUNTY

Farris Nursing Home
209 W. Market St., Columbia City
Mrs. Louise Farris
License expires 1-11-50

PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence		Elected	Served	Name and Residence		Elected	Served
Medical Convention							
*Livingston Dunlap, Indianapolis----		1849	1849	Charles S. Bond (acting), Richmond		1894	1895
Medical Society				*Miles F. Porter, Ft. Wayne -----		1895	1896
*William T. S. Cornett, Versailles----		1849	1850	*James H. Ford, Wabash -----		1896	1897
*Ashahel Clapp, New Albany-----		1850	1851	*William N. Wishard, Indianapolis--		1897	1898
*George W. Mears, Indianapolis-----		1851	1852	*John C. Sexton, Rushville-----		1898	1899
*Jeremiah H. Brower, Lawrenceburg--		1852	1853	*Walker Schell, Terre Haute-----		1899	1900
*Elizur H. Deming, Lafayette-----		1853	1854	*George W. McCaskey, Ft. Wayne----		1900	1901
*Madison J. Bray, Evansville-----		1854	1855	*Alembert W. Brayton, Indianapolis--		1901	1902
*William Lomax, Marion -----		1855	1856	*John B. Berteling, South Bend-----		1902	1903
*Daniel Meeker, LaPorte -----		1856	1857	Medical Association			
*Tahot Bullard, Indianapolis-----		1857	1858	*Jonas Stewart, Anderson-----		1903	1904
*Nathan Johnson, Cambridge City----		1858	1859	*George T. MacCoy, Columbus-----		1904	1905
*David Hutchinson, Mooresville-----		1859	1860	*George H. Grant, Richmond-----		1905	1906
*Benjamin S. Woodworth, Ft. Wayne		1860	1861	*George J. Cook, Indianapolis-----		1906	1907
*Theophilus Parvin, Indianapolis----		1861	1862	*David C. Peyton, Jeffersonville-----		1907	1908
*James F. Hibberd, Richmond-----		1862	1863	*George D. Kahlo, French Lick-----		1908	1909
*John Sloan, New Albany-----		1863	---	*Thomas C. Kennedy, Shelbyville-----		1909	1910
*John Moffett (acting), Rushville----		1863	1864	*Frederick C. Heath, Indianapolis----		1910	1911
*Samuel L. Linton, Columbus-----		1864	---	*William F. Howat, Hammond-----		1911	1912
*Wilson Lockhart (acting), Danville--		1864	1865	*A. C. Kimberlin, Indianapolis-----		1912	1913
*Myron H. Harding, Lawrenceburg--		1865	1866	*John P. Salb, Jasper-----		1913	1914
*Vierling Kersey, Richmond-----		1866	1867	*Frank B. Wynn, Indianapolis-----		1914	1915
*John S. Bobbs, Indianapolis-----		1867	1868	*George F. Keiper, Lafayette-----		1915	1916
*Nathaniel Field, Jeffersonville-----		1868	1869	*John H. Oliver, Indianapolis-----		1916	1917
*George Sutton, Aurora -----		1869	1870	*Joseph Rilus Eastman, Indianapolis		1917	1918
*Robert N. Todd, Indianapolis-----		1870	1871	William H. Stemm, North Vernon----		1918	1919
*Henry P. Ayres, Ft. Wayne-----		1871	1872	*Charles H. McCully, Logansport----		1919	1920
*Joel Pennington, Milton -----		1872	1873	*David Ross, Indianapolis-----		1920	1921
*Isaac Casselberry, Evansville -----		1873	---	William R. Davidson, Evansville----		1921	1922
*Wilson Hobbs (acting), Knights-				*Charles H. Good, Huntington-----		1922	1923
town -----		1873	1874	*Samuel E. Earp, Indianapolis-----		1923	1924
*Richard E. Houghton, Richmond----		1874	1875	Eldridge M. Shanklin, Hammond-----		1924	1925
*John H. Helm, Peru -----		1875	1876	Charles N. Combs, Terre Haute-----		1925	1926
*Samuel S. Boyd, Dublin -----		1876	1877	*Frank W. Cregor, Indianapolis-----		1926	1927
*Luther D. Waterman, Indianapolis----		1877	1878	George R. Daniels, Marion-----		1926	1928
*Louis Humphreys, South Bend-----		1878	---	Charles E. Gillespie, Seymour-----		1927	1929
*Benj. Newland (acting), Bedford				*Angus C. McDonald, Warsaw-----		1928	1930
(v.p.) -----		1878	1879	*Alois B. Graham, Indianapolis-----		1929	1931
*Jacob R. Weist, Richmond-----		1879	1880	Franklin S. Crockett, Lafayette----		1930	1932
*Thomas B. Harvey, Indianapolis----		1880	1881	Joseph H. Weinstein, Terre Haute--		1931	1933
*Marshall Sexton, Rushville-----		1881	1882	Everett E. Padgett, Indianapolis-----		1932	1934
*William H. Bell, Logansport-----		1882	1883	*Walter J. Leach, New Albany-----		1933	1935
*Samuel E. Munford, Princeton-----		1883	1884	Roscoe L. Sensenich, South Bend----		1934	1936
*James H. Woodburn, Indianapolis----		1884	1885	*Edmund D. Clark, Indianapolis-----		1935	1937
*James S. Gregg, Ft. Wayne-----		1885	1886	Herman M. Baker, Evansville-----		1936	1938
*General W. H. Kemper, Muncie-----		1886	1887	Edmund M. Van Buskirk, Ft. Wayne		1937	1939
*Samuel H. Charlton, Seymour-----		1887	1888	Karl R. Ruddell, Indianapolis-----		1938	1940
*William H. Wishard, Indianapolis----		1888	1889	Albert M. Mitchell, Terre Haute----		1939	1941
*James D. Gatch, Lawrenceburg-----		1889	1890	Maynard A. Austin, Anderson-----		1940	1942
*Gonsolvo C. Smythe, Greencastle----		1890	1891	Carl H. McCaskey, Indianapolis-----		1941	1943
*Edwin Walker, Evansville -----		1891-	1892	Jacob T. Oliphant, Farmersburg----		1942	1944
*George F. Beasley, Lafayette-----		1892	1893	Neslen K. Forster, Hammond-----		1943	1945
*Charles A. Daugherty, South Bend--		1893	1894	Jesse E. Ferrell, Fortville-----		1944	1946
*Elijah S. Elder, Indianapolis-----		1894	---	Floyd T. Romberger, Lafayette-----		1945	1947
				Cleon A. Nafe, Indianapolis-----		1946	1948
				Augustus P. Hauss, New Albany-----		1947	1949

* Deceased.

THE JOURNAL**OF THE****INDIANA STATE MEDICAL ASSOCIATION****DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA****Copyright 1949, Indiana State Medical Association****Office of Publication: 1017 Hume Mansur Building****Indianapolis 4, Indiana****Editor Emeritus: E. M. Shanklin, M.D., Hammond, Indiana****Editor: Frank B. Ramsey, M.D., 201 Hume Mansur Building, Indianapolis 4, Indiana****Associate Editor: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute, Indiana****Managing Editor: Ray E. Smith, 1017 Hume Mansur Building, Indianapolis 4, Indiana****Editorial Secretary: Mrs. Isabella Rowllison, 1017 Hume Mansur Building, Indianapolis 4, Indiana****Editorial Board:****Term Expires****Lall Montgomery, M.D., Muncie . . . Dec. 31, 1949****Pierce MacKenzie, M.D., Evansville . . Dec. 31, 1949****Jacob T. Ollphant, M.D., Farmersburg . Dec. 31, 1950****Kenneth G. Kohlstaedt, M.D., Indianapolis Dec. 31, 1950****Raymond F. Carmody, M.D., Gary . . . Dec. 31, 1951****E. L. Cartwright, M.D., Fort Wayne . Dec. 31, 1951****THE JOURNAL'S PLATFORM**

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

THE YEAR BOOK—1949 EDITION

THIS is the third edition of the Indiana Medical Year Book. Originally published as the January number of **THE JOURNAL**, it now appears as the July number. Change of publication date from the first to the middle of the year was made to facilitate the vast amount of editorial and clerical work which is required for its compilation. The volume of detail incidental to the Annual Meeting in the fall, and the work done in connection with sessions of the General Assembly make it more feasible to assemble the data for this number during the spring months.

The change of issue date also makes possible a more complete and accurate roster of members, since many of the changes in membership are effected in January. Another consideration which prompted the change was the thought that most doctors would welcome a break in the scientific articles during the summer months, rather than during the more studious winter months.

We are fortunate in obtaining a more durable cover for this issue. Those who make frequent reference to the Year Book will find that this will

lengthen the life of the issue, and make it more usable.

The only features of former numbers which have been repeated are those of changeable nature, such as the rosters, which are of value only if kept up-to-date. Articles appearing in the 1947 and 1948 editions, for which little or no change is indicated, have not been reprinted. Some readers will find that they may profitably retain all three Year Books for reference.

Included this year are items of current interest, such as the index and description of the newly codified Indiana Health Laws and the newly adopted A. M. A. Code of Ethics.

Also included in this issue, although not a part of the Year Book, is a serial of the Centennial Volume, *One-Hundred Years of Indiana Medicine*, which **THE JOURNAL** is proud to welcome to its pages.

As in the case of former Year Books, acknowledgment is made for the splendid and painstaking work which has been expended in preparation of

many of the medico-legal articles by Mr. Albert Stump, attorney for the state association.

THE JOURNAL is also indebted to the other contributors of articles pertaining to subjects in their specialty.

Publication of the Year Book involves a large amount of meticulous and careful work by the entire staff of the Association Headquarters office and THE JOURNAL office. Much of the clerical work is done at odd times for months in advance. Over-time hours and shortened vacations have been contributed by all concerned. It is a pleasure to give full credit to the members of the official staff who have made this issue possible.

MEDICAL RESEARCH

THE antivivisectionist movement is being conducted by an extremely small group which wields an influence out of all proportion to its size. It has been able to hinder medical research by sponsoring legislation inimical to animal experimentation, and by opposing laws designed to facilitate animal procurement.

The need for state laws to regulate the supply and use of live animals for biological research has long been realized. At present, dogs for laboratory use are obtained in many places on a system which is reminiscent of that used for anatomical material prior to passage of the Anatomical Act in 1903.

Laws which would make unclaimed impounded animals available to scientific institutions would, no doubt, improve the facilities for biological research in the same way that the Anatomical Act improved the facilities for the teaching of anatomy.

Minnesota recently enacted a law which legalizes the use of impounded animals which would otherwise be destroyed. There are twenty municipalities in the United States with similar laws, but Minnesota is the first state to adopt this type of legislation. Bills have been defeated in other states because of antivivisection activity.

Experience in Minnesota showed that the opposition to the proposed law consisted of a very small proportion of the people. An overwhelming majority of the citizens approved the plan when its purposes were explained to them.

The success of financial campaigns conducted annually by organizations such as the Cancer Society and the Heart Association has indicated indirectly that the public at large is interested in medical research, and that animal experimentation has its approval.

The magnitude of public approval, however, has been proved to be surprisingly large by a national opinion poll conducted by the National Opinion Research Center.

Eighty-five percent of the adult population in general were found to favor the use of live animals in medical teaching and research. Seven percent answered that they did not know, and only 8 percent opposed.

In answer to another question, 63 percent of the general population did not know that there were any groups opposed to use of animals in research.

Eighty-five percent of those questioned favored transfer of unclaimed pound animals to teaching institutions, rather than their destruction.

The Research Center report states: "People, today, favor the use of live animals in medical research and teaching by a wide margin. . . . There are, in fact, few issues for which such unanimity exists."

The Bulletin of The National Society for Medical Research editorializes as follows: "In order for the public, legislators, humane leaders and all other potential allies to become active, effective allies, they must be given an understanding of the goals, the methods and the achievements of the life sciences so that when they are exposed to a barrage of antivivisectionist propaganda they will recognize it for what it is and dismiss it accordingly."

A.M.A. FIGHTS FOR LIBERTY

At the forefront of the fight against Mr. Truman's proposed compulsory health insurance plan is the American Medical Association, which began its annual session yesterday in Atlantic City. Were it not for the vigorous efforts of this great organization, socialized medicine might now be a reality in this nation. The A.M.A. deserves a vote of thanks from all who oppose this scheme which is being paraded in the guise of social justice.

There has been nothing furtive about the A.M.A.'s battle against compulsory health insurance. It has fought in the open. It has launched a frank, straight-forward \$3,000,000 campaign to defeat the bill. For its efforts it has been viciously assailed by some proponents of the scheme, who would have the public think the association is a ruthless lobby with deplorably selfish, if not sinister, motives. Since the A.M.A. is the largest and most important organization of medical men in the United States, the smear artists are in effect attacking the character and integrity of the individual American doctor.

The A.M.A., however, will not be deterred by these attacks. Its spokesmen say it will welcome a showdown fight on the compulsory health insurance issue in the 1950 congressional elections. It begins to look as though the Truman strategy will be to let the bill be shelved in this session of Congress and then to "go to the people" in 1950.

There is nothing selfish or unworthy in any way about trying to safeguard a people against the lures and pitfalls of Socialism. In these troubled times it is one of the highest services which can be rendered. As the A.M.A. gathers this week in its annual session it is to be applauded for fighting the good fight.

The Indianapolis Star,
June 7, 1949

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of the members of the Indiana State Medical Association, including the names of all those who were members on June 1, 1949. Membership established after that date could not be included in this issue of THE JOURNAL. Members are listed in the county in which they hold their membership.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

A

Name	City	County	Name	City	County
Aagesen, J. W.	Anderson	Madison	Alford, James	Hamilton	Steuben
Abel, J. A.	South Bend	St. Joseph	Allegretti, Michael	Hammond	Lake
Abel, Virgil	Vallonia	Jackson	Allen, Fred K.	Salem	Washington
Abell, Charles F.	Marion	Grant	Allen, Hubert E.	Richmond	Wayne-Union
Acher, Robert P.	Greensburg	Decatur	Allen, J. L.	Greenfield	Hancock
Acker, Robert B.	South Bend	St. Joseph	Allen, L. Howard	Bedford	Lawrence
Acre, R. R.	Evansville	Vanderburgh	Allen, Orris T.	Terre Haute	Vigo
Adair, Fred L.	Chesterton	Porter	Allen, Robert T.	Indianapolis	Wayne-Union
Adair, Samuel L.	Jeffersonville	Clark	Almquist, C. O.	Gary	Lake
Adair, Wm. K.	Crothersville	Jackson	Altier, W. H.	Fowler	Benton
Adams, C. J.	Kokomo	Howard	Alvey, Charles R.	Muncie	Delaware- Blackford
Adams, J. R.	Ft. Wayne	Allen			
Adams, Max R.	Flora	Carroll	Alvis, Edmond O.	Indianapolis	Marion
Adams, William B.	Muncie	Delaware- Blackford	Alward, John Haney	Akron, Ohio	Marion
			Ambrose, J. C.	Noblesville	Hamilton
Adamski, Michael S.	Logansport	Cass	Ames, George (H)	Eaton	Delaware- Blackford
Ade, C. H.	Lafayette	Tippecanoe			
Ade, Mary	Lafayette	Tippecanoe	Amick, Charles L.	Wakarusa	Elkhart
Adkins, H. C.	Indianapolis	Marion	Amos, R. L.	New Castle	Henry
Adkins, Onan C.	Indianapolis	Marion	Amstutz, Henry C.	Goshen	Elkhart
Adler, David L.	Columbus	Bartholomew- Brown	Amy, W. E.	Corydon	Harrison
			Anderson, D. W.	Evansville	Vanderburgh
Adler, Edmund R.	Dyer	Lake	Anderson, R. J.	Indianapolis	Marion
Adler, Raymond N.	Evansville	Vanderburgh	Anderson, R. M.	Vincennes	Knox
Agee, Ernest B., Jr.	Terre Haute	Vigo	Anderson, Walter C.	Terre Haute	Vigo
Ahlering, George H.	Farmland	Randolph	Anderson, W. C.	Indianapolis	Marion
Aiken, Arthur F.	Ft. Wayne	Allen	Annis, Homer B.	Bluffton	Wells
Aiken, Milo M.	Plainfield	Hendricks	Antes, Earl H.	Evansville	Vanderburgh
Aiken, N. E.	Ft. Wayne	Allen	Anthoulis, George D.	Gary	Lake
Ake, Loren	Richmond	Wayne-Union	Appel, R. H.	Indianapolis	Marion
Aker, Charles L.	Greencastle	Putnam	Applegate, Albert E.	Frankfort	Clinton
Albertson, F. P.	Indianapolis	Marion	Applegate, F. M.	Monahans, Texas	Harrison
Albrecht, J. R.	Vincennes	Knox			
Albright, Victor F.	New Castle	Henry	Arbeiter, Herbert I.	Hammond	Lake
Aldrich, Harry	Indianapolis	Marion	Arbogast, John L.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion	Arbogast, Paul B.	Vincennes	Knox
Aldridge, J. W.	Covington	Fountain- Warren	Arbuckle, Wm. E.	Indianapolis	Marion
			Arford, R. D.	Middletown	Henry
Alexander, Ezra D.	Indianapolis	Marion	Arisman, R. K.	South Bend	St. Joseph
Alexander, H. H.	Princeton	Gibson	Arlook, Theodore D.	Indianapolis	Elkhart
Alexander, J. E.	Evansville	Vanderburgh	Armington, C. L.	Anderson	Madison
Alexander, O. O.	Terre Haute	Vigo	Armington, John C.	Anderson	Madison
Alexander, P. M.	Martinsville	Morgan	Armington, Robert	Anderson	Madison
Alexander, Stephen J.	Crawfordsville	Montgomery	Armstrong, T. D.	Michigan City	La Porte

Name	City	County	Name	City	County
Arnett, A. C.	Lafayette	Tippecanoe	Barnhart, Willard T.	Evansville	Vanderburgh
Arnold, Aaron L.	Indianapolis	Marion	Barone, Carmelo V.	Mishawaka	St. Joseph
Arnold, Marion	East Chicago	Lake	Barrett, D. C.	Indianapolis	Bartholomew-Brown
Aronson, Sidney S.	Indianapolis	Marion	Barrow, John H.	Dale	Spencer
Arrowsmith, James L.	Hammond	Lake	Barry, M. J.	Indianapolis	Marion
Arthur, H. M. (H)	Hazleton	Gibson	Barry, Maurice J., Jr.	Indianapolis	Marion
Arthur, N. Maude	Washington	Daviess-Martin	Bartholomew, A. C.	Fort Wayne	Allen
Asbury, W. D.	Terre Haute	Vigo	Bartholomew, Mary	Goshen	Elkhart
Ash, H. H.	West Lafayette	Tippecanoe	Bartle, J. Leo	Indianapolis	Marion
Asher, E. O.	New Augusta	Marion	Bartlett, Robert C.	Dublin	Wayne-Union
Asher, James W.	New Augusta	Marion	Bartley, Max D.	Indianapolis	Marion
Ashworth, L. N.	Connersville	Fayette-Franklin	Barton, Robert	Angola	Steuben
Atchison, K. C.	Rockport	Spencer	Barton, W. M.	Centerville	Wayne-Union
Atkins, C. C.	Rushville	Rush	Bartsch, Harvey L.	South Bend	St. Joseph
Atkinson, C. W.	Boswell	Benton	Bash, Wallace E.	Fort Wayne	Allen
Aucerman, C. J.	Bluffton	Wells	Baskett, R. J.	Jonesboro	Grant
Ault, Roy, Sr.	Terre Haute	Vigo	Bassett, Clancy	Thorntown	Boone
Austin, Eugene W.	Evansville	Vanderburgh	Bassett, Margaret	Thorntown	Boone
Austin, F. H. (H)	Bloomington	Owen-Monroe	Bassler, C. R.	Mishawaka	St. Joseph
Austin, M. A.	Anderson	Madison	Batman, Gordon W.	Indianapolis	Marion
Austin, R. P.	Bedford	Lawrence	Battersby, J. Stanley	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison	Batties, Paul A.	Indianapolis	Marion
Ayres, W. W.	Marion	Grant	Bauer, A. J.	Lafayette	Tippecanoe
B			Bauer, Thomas B.	Indianapolis	Marion
Babb, Forrest J.	Stockwell	Tippecanoe	Baughn, William L.	Anderson	Madison
Bachmann, Arnold J.	Indianapolis	Marion	Baum, Harry	Indianapolis	Marion
Backer, Henry G.	Ferdinand	Dubois	Baumgartner, Jeraldine	Fort Wayne	Allen
Badders, A. C.	Portland	Jay	Baxter, J. W., Jr.	New Albany	Floyd
Bahr, Max A.	Indianapolis	Marion	Baxter, Neal	Bloomington	Owen-Monroe
Bailey, Edwin B.	Linton	Greene	Baxter, Samuel M.	New Albany	Floyd
Bailey, E. W.	Logansport	Cass	Bayley, R. H.	Lafayette	Tippecanoe
Bailey, L. S.	Zionsville	Boone	Bayley, William E.	Lafayette	Tippecanoe
Bailey, Paul P.	Fort Wayne	Allen	Baylor, Edward M.	Evansville	Vanderburgh
Bailey, Wm. A. (H)	Vincennes	Knox	Beach, Robert R.	Indianapolis	Marion
Baitinger, H. M.	Gary	Lake	Beam, Vernon B.	East Chicago	Lake
Bakemeier, O. H.	Indianapolis	Marion	Beams, Ralph H.	Fort Wayne	Allen
Baker, A. M.	New Albany	Floyd	Bean, Joseph S.	Indianapolis	Marion
Baker, C. S.	Evansville	Spencer	Bear, L. H. (H)	Vevay	Switzerland
Baker, G. D.	Crandall	Harrison	Beardsley, John	Frankfort	Clinton
Baker, Herman	Evansville	Vanderburgh	Beardsley, Frank A.	Frankfort	Clinton
Baker, J. S.	Evansville	Vanderburgh	Beasley, T. J.	Indianapolis	Marion
Baker, Leslie M.	Aurora	Dearborn-Ohio	Beaver, Ernest R.	Rensselaer	Jasper-Newton
Baker, Milan D.	Culver	Marshall	Beaver, Norman	Berne	Adams
Baker, Robert E. (H)	Orleans	Orange	Beaver, Howard W.	Indianapolis	Marion
Baker, Warren	Michigan City	La Porte	Bechtol, Lavon D.	Indianapolis	Marion
Bakes, Fred C.	Los Angeles, Calif.	Switzerland	Bechtold, S. E.	South Bend	St. Joseph
Balch, James F.	Indianapolis	Marion	Beck, Evart M.	Indianapolis	Marion
Baldrige, W. O.	Terre Haute	Vigo	Beck, H. A.	Lebanon	Boone
Balkema, Cath. M.	Lafayette	Tippecanoe	Beck, Robert A.	Kalispel, Montana	Vigo
Ball, Clay A.	Muncie	Delaware-Blackford	Becker, Philip H.	Crown Point	Lake
Ball, Joseph E.	Indianapolis	Marion	Beckes, Ellsworth	Vincennes	Knox
Ball, Thomas Z. (H)	Crawfordsville	Montgomery	Beckes, Norman E. (H)	Vincennes	Knox
Balla, Morris	South Bend	St. Joseph	Beckman, H. F.	Indianapolis	Marion
Ballard, C. A.	Logansport	Cass	Becomovich, Robert	Hammond	Lake
Ballard, Robert J.	Lebanon	Boone	Bedwell, Marion H.	Sullivan	Sullivan
Ballenger, W. E.	Richmond	Wayne-Union	Beeler, Bruce H.	Evansville	Vanderburgh
Balsbaugh, George	N. Manchester	Wabash	Beeler, Raymond C.	Indianapolis	Marion
Baltes, Joseph H.	Fort Wayne	Allen	Beetem, L. F.	Madison	Jefferson
Banister, R. F.	Indianapolis	Marion	Beggs, L. F.	Columbus	Bartholomew-Brown
Bankoff, Milton L.	Michigan City	La Porte	Behn, Walter M.	Gary	Lake
Banks, H. M.	Indianapolis	Marion	Beierlein, Karl	Fort Wayne	Allen
Barclay, I. C.	Evansville	Vanderburgh	Beilke, Clifford A.	East Chicago	Lake
Bard, Frank B.	Crothersville	Jackson	Belshaw, G. H.	Fairmount	Grant
Barnard, P. C. (H)	Parker	Delaware-Blackford	Benchik, Frank A.	East Chicago	Lake
Barnes, Helen B.	Greenwood	Johnson	Bender, Cecil K.	Goshen	Elkhart
Barnett, Ernest R.	Alhambra, Cal.	Marion	Bender, Robert L.	Elkhart	Elkhart
Barnett, R. E.	Peru	Miami	Bendler, Carl H.	Gary	Lake
			Benedek, Tibor	East Chicago	Lake
			Benedict, Charles D.	LaGrange	LaGrange
			Bennett, Abner P.	Evansville	Vanderburgh

Name	City	County
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benninghoff, D. R.	Fort Wayne	Allen
Benz, Jesse	Marengo	Crawford
Benz, O. F.	Wanatah	LaPorte
Bergan, Joseph A.	East Chicago	Lake
Bergen, Paul M.	Lowell	Lake
Berger, Henry I.	Indianapolis	Marion
Berger, Morley	Beech Grove	Marion
Berghoff, Raymond	Fort Wayne	Allen
Berke, Robert	South Bend	St. Joseph
Berkebile, J. B.	Peru	Miami
Berman, Jacob K.	Indianapolis	Marion
Bernheimer, H. L. (H)	Terre Haute	Vigo
Bernoske, D. G.	Michigan City	La Porte
Best, M. M.	New Albany	Floyd
Bethea, Dennis A.	Hammond	Lake
Beverland, M. E.	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph
Bibler, Henry E.	Muncie	Delaware- Blackford
Bibler, L. D.	Indianapolis	Marion
Bickel, David A.	South Bend	St. Joseph
Bickel, J. E.	Fort Wayne	Allen
Bierly, Fred	Elizabeth	Floyd
Bigelow, O. P.	Roanoke	Huntington
Bill, Robert O.	Topeka, Kans.	Marion
Billman, Gustus S.	Shelbyville	Shelby
Bills, L. F.	Culver	Lake
Bills, R. N.	Gary	Lake
Bird, Charles R.	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birmingham, P. J.	South Bend	St. Joseph
Bishop, Charles A.	South Bend	St. Joseph
Bishop, Harry A.	Frankton	Madison
Bitler, C. C.	New Castle	Henry
Bixler, Louis C.	South Bend	St. Joseph
Bizer, Mier A.	Jeffersonville	Clark
Black, Claude S.	Warren	Huntington
Black, Edgar K.	Wabash	Wabash
Black, Joe M.	Seymour	Jackson
Blackburn, Erwin	South Bend	St. Joseph
Blackford, Roger W.	Russellville, Ark.	Marion
Blaize, J. L.	New Castle	Henry
Bland, Curtis	Oaktown	Knox
Bland, H. E. (H)	Fairbanks	Sullivan
Blassaras, Christ	Anderson	Madison
Blatt, A. E.	Indianapolis	Marion
Blazey, A. G.	Washington	Daviess- Martin
Bledsoe, James G.	New Castle	Henry
Blemker, Russell M.	Greensburg	Decatur
Blessinger, Louis Henry	Huntingburg	Dubois
Blessinger, Paul J.	Jasper	Dubois
Blix, Fred M.	Ladoga	Montgomery
Bloemker, E. F.	Indianapolis	Marion
Bloom, Asa Ward	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, J. R.	Rockville	Parke- Vermillion
Bloomer, R. S.	Rockville	Parke- Vermillion
Blosser, B. A.	Fremont	Steuben
Blosser, H. V. (H)	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne- Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl	Gary	Lake
Boaz, John J.	Indianapolis	Marion

Name	City	County
Bodnar, Leslie M.	South Bend	St. Joseph
Bogardus, C. R.	Austin	Scott
Boggs, E. F.	Indianapolis	Marion
Bohner, C. B.	Indianapolis	Marion
Bolin, John T.	Hammond	Lake
Bolin, Robert S.	Elkhart	Elkhart
Bolka, B. J.	South Bend	St. Joseph
Bolman, Ralph M.	Fort Wayne	Allen
Bonaventura, A. P.	East Chicago	Lake
Bond, Charles S. (H)	Richmond	Wayne- Union
Bond, Walter	Clay City	Clay
Bonifield, H. F.	Warren	Huntington
Booher, Irvin E.	Connersville	Fayette- Franklin
Booher, Norman R.	Indianapolis	Marion
Booher, Olga	Indianapolis	Marion
Bopp, D. W.	Whiting	Lake
Bopp, Henry W.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borak, Walter J.	Gary	Lake
Borders, Theo. R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (H)	Poseyville	Posey
Borland, R. M.	Bloomington	Owen- Monroe
Borough, L. D.	South Bend	St. Joseph
Boswell, Robert W.	Evansville	Vanderburgh
Bothwell, C. G.	Martinsville	Morgan
Botkin, Clyde G.	Muncie	Delaware- Blackford
Botkin, Thomas	Muncie	Delaware- Blackford
Bottorff, David C.	Charlestown	Clark
Boughman, Joseph D.	Kokomo	Howard
Bounnell, Harry M. (H)	Waynetown	Montgomery
Bowdoin, G. E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bower, Daniel L.	Indianapolis	Marion
Bowers, Copeland C.	Kokomo	Howard
Bowers, Don D.	Indianapolis	Marion
Bowers, G. T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, John A.	Kokomo	Howard
Bowers, J. W.	Fort Wayne	Allen
Bowles, J. H.	Muncie	Delaware- Blackford
Bowman, Charles M.	Albion	Noble
Bowman, George W.	Indianapolis	Marion
Boyd, C. L.	Vincennes	Knox
Boyd, Charles S.	East Chicago	Lake
Boyd, Clarence E.	West Baden	Orange
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, E. B.	Indianapolis	Marion
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boylan, Malcolm	Anderson	Madison
Boys, Floyd E.	Urbana, Ill.	Marion
Boys, F. F.	East Chicago	Lake
Bradfield, John C.	Logansport	Cass
Bradley, Stephen C.	Terre Haute	Vigo
Brady, Samuel	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brandman, Harry	Gary	Lake
Brauchla, C. H.	Anderson	Madison
Braun, Benjamin D.	East Chicago	Lake
Braunlin, Robert F.	Marion	Grant
Braunlin, W. H.	Marion	Grant
Braunsdorf, R. L.	South Bend	St. Joseph
Brauer, A. A.	East Chicago	Lake

Name	City	County	Name	City	County
Brayton, John R.	Indianapolis	Marion	Buckner, Joy F.	Bluffton	Wells
Brayton, Lee	Indianapolis	Marion	Buechner, F. W.	South Bend	St. Joseph
Brazelton, O. T.	Princeton	Gibson	Buehl, Robert F.	Indianapolis	Marion
Brenner, Andrew M.	Winchester	Randolph	Buhrmester, H. C.	Lafayette	Tippecanoe
Brenner, I. E.	Winchester	Randolph	Buikstra, C. R.	Evansville	Vanderburgh
Bretz, John M.	Huntingburg	Dubois	Bullard, Mattie J.	Gary	Lake
Bretz, W. D.	Huntingburg	Dubois	Bulson, Eugene L.	Ft. Wayne	Allen
Brickley, H. D.	Bluffton	Wells	Bundy, C. Merle	Indianapolis	Washington
Bridges, William L.	Markleville	Madison	Bunker, L. Z.	N. Manchester	Wabash
Bridwell, Edgar	Bedford	Lawrence	Burcham, J. B.	Gary	Lake
Briggs, Carl F.	Sullivan	Sullivan	Burdette, Harold F.	Indianapolis	Marion
Briggs, J. H.	Churubusco	Whitley	Burge, A. D.	Marion	Grant
Brink, Calvin C.	Gary	Lake	Burghard, D. Rolla	Indianapolis	Marion
Briscoe, C. E.	New Albany	Floyd	Burk, James M.	Decatur	Adams
Britton, W. D.	Montezuma	Parke- Vermillion	Burkhardt, B. A.	Tipton	Tipton
			Burkle, J. C.	Lafayette	Tippecanoe
Brock, Earl E.	Anderson	Madison	Burks, Jess E.	Crawfordsville	Montgomery
Brockmole, Arnold W.	Evansville	Vanderburgh	Burman, Richard G.	Jeffersonville	Clark
Brodie, Donald W.	Indianapolis	Marion	Burnett, Arthur B.	Indianapolis	Henry
Bronson, Paul J.	Terre Haute	Vigo	Burney, Leroy E.	Indianapolis	Marion
Brookie, Roger Wm.	Flora	Carroll	Burnikel, Ray H.	Evansville	Vanderburgh
Brooks, H. L.	Michigan City	LaPorte	Burns, Paul E.	Montpelier	Delaware- Blackford
Broomes, Edward L. C.	East Chicago	Lake			
Broshears, Kenneth	Linton	Greene	Burress, B. O.	Washington	Daviess- Martin
Brosius, Robert H. W.	Ft. Wayne	Allen			
Brother, Geo. M.	Indianapolis	Marion	Burris, F. L.	Michigan City	La Porte
Brown, A. E.	Indianapolis	Marion	Burroughs, C. A.	Frankfort	Clinton
Brown, D. B.	Gary	Lake	Burrous, E. Lee	Peru	Miami
Brown, David E.	Indianapolis	Marion	Burt, James C.	New York, N. Y.	Marion
Brown, Dewitt W.	Indianapolis	Marion			
Brown, Edward A. (H)	Indianapolis	Marion	Bush, Hargis R.	Cannelton	Perry
Brown, Frances T.	Indianapolis	Marion	Bussard, C. F.	South Bend	St. Joseph
Brown, Frederic W.	Ft. Wayne	Allen	Bussard, Frank	South Bend	St. Joseph
Brown, George E.	Greenwood	Johnson	Butler, John O.	Farmersburg	Sullivan
Brown, James A. Sr.	Evansville	Vanderburgh	Butman, W. C.	Hebron	Porter
Brown, James C.	Valparaiso	Porter	Butterfield, Robt. M.	Muncie	Delaware- Blackford
Brown, J. S.	Carlisle	Sullivan			
Brown, Karl T.	Muncie	Delaware- Blackford	Buttz, Rose J.	Indianapolis	Marion
			Buxton, Eva J. (H)	Rockport	Spencer
Brown, K. H.	New Albany	Floyd	Byerly, Frederick L.	Winston- Salem, N.C.	Allen
Brown, Leland G.	Indianapolis	Marion			
Brown, Leo R.	Gary	Lake	Byers, Norman R.	Bedford	Lawrence
Brown, M. S.	Spencer	Owen- Monroe	Byrn, H. W.	New Albany	Floyd
			Byrne, Robert J.	Bicknell	Knox
Brown, R. E.	Cayuga	Parke- Vermillion			
			C		
Brown, Robert L.	Evansville	Vanderburgh	Cabell, A. L. (H)	Terre Haute	Vigo
Brown, Robert R.	Terre Haute	Vigo	Cacia, John J.	Evansville	Vanderburgh
Brown, Robert M.	Marion	Grant	Cahal, E. E.	Indianapolis	Marion
Brown, Stanley L.	Hammond	Lake	Cahn, Hugo M.	Indianapolis	Vigo
Brown, Stewart D.	Albany	Delaware- Blackford	Cajacob, Melville E.	Terre Haute	Vigo
			Caldwell, William C.	Evansville	Vanderburgh
Brown, Thomas	Delphi	Carroll	Call, E. B.	Knightstown	Henry
Brown, Wendell E.	Indianapolis	Marion	Call, H. F.	Indianapolis	Marion
Browne, William A.	Evansville	Vanderburgh	Callaghan, W. C.	Greensburg	Decatur
Browning, J. S.	Indianapolis	Marion	Callahan, R. H.	East Chicago	Lake
Browning, W. M.	Indianapolis	Marion	Calvert, R. R.	Lafayette	Tippecanoe
Brubaker, E. H. (H)	Indianapolis	Marion	Calvin, Jessie C. (H)	Fort Wayne	Allen
Brubaker, Harold S.	Huntington	Huntington	Calvy, William J.	Indianapolis	Marion
Brubaker, O. G.	N. Manchester	Wabash	Cameron, D. F.	Ft. Wayne	Allen
Bruegge, T. J.	Kokomo	Howard	Campagna, E. A.	East Chicago	Lake
Bruetsch, Walter L.	Indianapolis	Marion	Campbell, J. A.	Indianapolis	Marion
Bruggeman, H. O.	Ft. Wayne	Allen	Campbell, P. A.	Richmond	Wayne-Union
Bruner, Ralph	Jeffersonville	Clark	Campbell, Sam W.	Carmel	Hamilton
Bryan, F. A.	Marion	Grant	Canaday, C. E.	New Castle	Henry
Bryan, Robert E.	Kendallville	Noble	Canaday, J. W.	Indianapolis	Marion
Bryan, Robert J.	South Bend	St. Joseph	Cannon, Daniel H.	New Albany	Floyd
Bryan, S. L.	Evansville	Vanderburgh	Caplin, Irvin	Indianapolis	Marion
Buchanan, W. D.	South Bend	St. Joseph	Caplin, S. S.	Indianapolis	Marion
Buche, F. P.	Richmond	Wayne- Union	Carbone, J. A.	Gary	Lake
			Carey, W. W. (H)	Ft. Wayne	Allen
Buchholz, Ransom R.	Evansville	Vanderburgh	Carlberg, D. L.	Jeffersonville	Clark
Buck, Charles E.	Indianapolis	Marion	Carleton, E. H.	East Chicago	Lake
Buckingham, Richard	Bloomington	Owen-Monroe	Carlo, Ernest R.	Ft. Wayne	Allen
Buckles, David L.	Anderson	Madison	Carlo, J. F.	Hammond	Lake
Buckley, E. P.	Clarksville	Clark	Carlson, E. A.	Peru	Miami
Buckner, Doster	Ft. Wayne	Allen			

Name	City	County	Name	City	County
Carlson, Norman C.	Michigan City	Lake	Coble, F. H.	Richmond	Wayne-Union
Carlyle, Ivan E.	Michigantown	Clinton	Coble, R. R.	Indianapolis	Marion
Carmichael, C. S.	Seelyville	Vigo	Cockrum, Wm. M.	Evansville	Vanderburgh
Carmody, R. F.	Gary	Lake	Cody, B. L.	Evansville	Vanderburgh
Carneal, Thomas E.	Winamac	Pulaski	Coffel, Melvin H.	Vincennes	Knox
Carnes, Wm. M.	Earl Park	Benton	Coffman, Delmar Lee	Clinton, Okla.	Vanderburgh
Carney, J. T.	Jeffersonville	Clark	Cohn, Jess V.	Indianapolis	Marion
Carney, John C.	Monticello	Tippecanoe	Cohn, Phillip	New Albany	Floyd
Carpenter, G. C.	Terre Haute	Vigo	Cole, A. V.	East Chicago	Lake
Carpenter, J. L.	Alexandria	Madison	Cole, Ira	Lafayette	Tippecanoe
Carpenter, Thomas D.	Columbus	Bartholomew-	Cole, Russel E.	Muncie	Delaware-
		Brown			Blackford
Carpentier, Harry F.	Princeton	Gibson	Cole, Wm. L.	Evansville	Vanderburgh
Carrel, Francis E.	Frankfort	Clinton	Coleman, Floyd B.	Waterloo	Dekalb
Carroll, John C.	Decatur	Adams	Coleman, H. G.	Odon	Daviess-
Carson, Wayne	Indianapolis	Marion			Martin
Carter, F. R. Nicholas	South Bend	St. Joseph	Coleman, W. H.	Evansville	Vanderburgh
Carter, Fred S.	Bluffton	Wells	Colglazier, G. G.	Leipsic	Orange
Carter, James C.	Indianapolis	Marion	Colip, George	South Bend	St. Joseph
Carter, J. V.	Tipton	Tipton	Collett, Hugh S.	Bluffton	Wells
Carter, Oren E.	Indianapolis	Marion	Collins, Albert W. (H)	Anderson	Madison
Cartwright, E. L.	Ft. Wayne	Allen	Collins, Hubert L.	Indianapolis	Marion
Cartwright, Jack D.	LaPorte	LaPorte	Collins, J. N.	Indianapolis	Marion
Casebeer, P. B.	Clinton	Parke-	Coloviras, George, Jr.	Lafayette	Tippecanoe
		Vermillion	Combs, Charles N.	Terre Haute	Vigo
Caseley, Donald J.	Indianapolis	Marion	Combs, Herman	Evansville	Vanderburgh
Casey, Stanley M.	Huntington	Huntington	Combs, John H.	Evansville	Vanderburgh
Casper, Joseph F.	Jasper	Dubois	Combs, Loyal Wm., Jr.	Lowell	Lake
Casper, J. P.	Jasper	Dubois	Combs, Nelson B.	Mulberry	Clinton
Cassady, J. V.	South Bend	St. Joseph	Combs, Pearl B.	Evansville	Vanderburgh
Catlett, M. B.	Ft. Wayne	Allen	Combs, Stuart R.	Terre Haute	Vigo
Caton, J. R.	South Bend	St. Joseph	Comer, Charles W.	Mooreville	Morgan
Cavitt, Robert F.	Indianapolis	Marion	Comer, J. E.	Mooreville	Morgan
Cavins, A. W.	Terre Haute	Vigo	Comer, Kenneth E.	Mooreville	Morgan
Cayley, Frank J.	Indianapolis	Marion	Compton, C. B.	Frankfort	Clinton
Caylor, Harold D.	Bluffton	Wells	Compton, George	Tipton	Tipton
Caylor, Truman E.	Bluffton	Wells	Compton, Walter A.	Elkhart	Elkhart
Challman, W. B.	Mount Vernon	Posey	Condit, David H.	South Bend	St. Joseph
Chambers, A. R.	Fort Wayne	Allen	Conger, Elizabeth (H)	Indianapolis	Marion
Chambers, L. B.	Union City	Randolph	Congleton, G. C.	Terre Haute	Vigo
Chambers, William	South Bend	St. Joseph	Conklin, James O.	Terre Haute	Vigo
Chandler, L. H.	Millersburg	Elkhart	Conklin, R. L.	Elkhart	Elkhart
Charles, Etta (H)	Anderson	Madison	Conley, John E.	Ft. Wayne	Allen
Chattin, Herbert O.	Vincennes	Knox	Conley, Joseph L.	Indianapolis	Marion
Chattin, Robert E.	Loogootee	Daviess-Martin	Conley, T. M.	Kokomo	Howard
Chattin, V. J.	Washington	Daviess-Martin	Connell, P. S.	Plymouth	Marshall
Chen, K. K.	Indianapolis	Marion	Connell, Vactor O.	Bourbon	Marshall
Chester, H. R.	Prescott, Ariz.	Allen	Connolly, J. J.	Terre Haute	Vigo
Chevigny, J. J.	Gary	Lake	Conner, T. E. (H)	Freetown	Jackson
Chidlaw, B. W.	Hammond	Lake	Connerley, M. L.	Chelsea, Mass.	Marion
Childs, Wallace E.	Indianapolis	Gibson	Connoy, Andrew F.	Westfield	Hamilton
Chittick, A. G.	Frankfort	Clinton	Connoy, Leo	Westfield	Hamilton
Christophel, Verna	Mishawaka	St. Joseph	Conover, Earl	Evansville	Vanderburgh
Clancy, J. F.	Hammond	Lake	Conrad, E. M. (H)	Anderson	Madison
Clapp, Fred R.	South Bend	St. Joseph	Conrad, Henry W.	Milan	Ripley
Clark, C. P.	Indianapolis	Marion	Conway, Chester C.	Indianapolis	Marion
Clark, Cyrus J.	Indianapolis	Marion	Conway, Glenn	Indianapolis	Marion
Clark, Fred O.	Syracuse	Elkhart	Cook, C. J. (H)	Indianapolis	Marion
Clark, Ivan A.	Paoli	Orange	Cook, Charles E.	North	Wabash
Clark, Joseph H.	Ft. Wayne	Allen		Manchester	
Clark, L. J.	Indianapolis	Marion	Cook, E. C.	Madison	Jefferson
Clark, M. E.	Cambridge City	Wayne-Union	Cook, G. M.	Hammond	Lake
Clark, Stanley A.	South Bend	St. Joseph	Cook, Gordon C.	South Bend	St. Joseph
Clark, Wm. H.	South Bend	St. Joseph	Cook, Norman R.	Richmond	Wayne-Union
Clark, W. R.	Ft. Wayne	Allen	Cook, Robert G.	Bluffton	Wells
Clarke, Elton R.	Kokomo	Howard	Cooksey, T. L. (H)	Crawfordsville	Montgomery
Clauser, E. H.	Muncie	Delaware-	Coomes, M. J. (H)	Shelbyville	Shelby
		Blackford	Cooney, Charles J.	Ft. Wayne	Allen
Clements, A. F.	Evansville	Vanderburgh	Coons, John D.	Lebanon	Boone
Clevenger, J. H.	Muncie	Delaware-	Cooper, H. L.	South Bend	St. Joseph
		Blackford	Cooper, Leo Kenneth	Gary	Lake
Clevinger, Wm. G.	Kirklin	Clinton	Cooper, Thomas L.	Logansport	Cass
Cline, Kenneth L.	Wyatt	St. Joseph	Copeland, G. W. (H)	Vevay	Switzerland
Close, W. D.	Indianapolis	Marion	Copeland, S. J.	Indianapolis	Marion
Clouse, Paul A.	Evansville	Vanderburgh	Corcoran, Patrick J. V.	Evansville	Vanderburgh
Clunie, Wm. A.	Corydon	Harrison	Cormican, Herbert L.	Elkhart	Elkhart
Coats, Edwin A.	New Castle	Henry	Cornacchione, M.	Indianapolis	Marion
			Cornell, Beaumont S.	Ft. Wayne	Adams

Name	City	County	Name	City	County
Cornell, Robert A.	Crawfordsville	Montgomery	Dalton, William F.	Indianapolis	Marion
Corpe, Kenneth F.	Rushville	Rush	Dancer, C. R. (H)	Fort Wayne	Allen
Cortese, Thomas A.	Indianapolis	Marion	Dando, George H. (H)	Hartford City	Delaware- Blackford
Cotter, E. R.	East Chicago	Lake	Daniel, J. C.	Indianapolis	Marion
Cotterman, Vernon L.	Gary	Lake	Danieleski, L. J.	Gary	Lake
Cotton, S. M.	Goldsmith	Tipton	Daniels, E. O.	Marion	Grant
Coulson, S. B.	Waldron	Shelby	Daniels, G. R.	Marion	Grant
Courtney, John W.	Indianapolis	Marion	Dannacher, William D.	Wabash	Wabash
Coultas, P. J.	Tell City	Perry	Dare, Lee A.	Jeffersonville	Clark
Covalt, Wendell E.	Muncie	Delaware- Blackford	Darling, Dorothy	Gary	St. Joseph
Covell, H. M.	Auburn	Dekalb	Darroch, S. C.	Cayuga	Parke- Vermillion
Cox, C. E.	Indianapolis	Marion	Dasse, R. J.	Logansport	Cass
Cox, Harold	Indianapolis	Marion	Dassell, Paul Milton	Hammond	Lake
Cox, Leon T.	Richmond	Wayne-Union	Daubenheyer, M. F.	Butlerville	Jennings
Cox, W. T.	Lafayette	Tippecanoe	Daugherty, F. N.	Crawfordsville	Montgomery
Coy, Francis M.	Anderson	Madison	Daves, W. L.	Evansville	Vanderburgh
Coyner, A. B.	Lafayette	Tippecanoe	Davidoff, Manuel A.	Ossian	Wells
Craft, K. L.	Indianapolis	Marion	Davidson, N. Cort	Indianapolis	Marion
Craft, William F.	Linton	Greene	Davidson, Wm. D.	Evansville	Vanderburgh
Craig, Alexander F.	Indianapolis	Henry	Davidson, W. R.	Evansville	Vanderburgh
Craig, R. A.	Kokomo	Howard	Davis, Alice H.	Hammond	Lake
Craig, Richard M.	Ft. Wayne	Allen	Davis, Carl M.	Valparaiso	Porter
Craig, Robert A.	Syracuse	Elkhart	Davis, D. F. (H)	New Albany	Floyd
Crain, James Wm.	Williamsport	Fountain- Warren	Davis, E. C.	Muncie	Delaware- Blackford
Cramp, Arthur J. (H)	Hendersonville,	Porter	Davis, George D.	Rochester,	Marion
	N. Car.			Minn.	
Crampton, C. C. (H)	Delphi	Carroll	Davis, J. A.	Flat Rock	Shelby
Crandall, Latham A.	Elkhart	Elkhart	Davis, John A.	Indianapolis	Marion
Crawford, James H.	Evansville	Vanderburgh	Davis, John C.	Logansport	Cass
Crawford, John A.	Indianapolis	Marion	Davis, Joseph B.	Marion	Grant
Crawford, W. G.	Terre Haute	Vigo	Davis, M. S.	Marion	Grant
Creel, Donald	Angola	Steuben	Davis, Marvin R.	Columbus	Bartholomew- Brown
Crevello, Albert J.	Evansville	Vanderburgh	Davis, Neal	Lowell	Lake
Crimm, Paul D.	Evansville	Vanderburgh	Davis, Parvin M.	New Albany	Floyd
Cring, George	Portland	Jay	Davis, Sam J.	Indianapolis	Marion
Cripe, E. P.	Bremen	Marshall	Day, C. W.	Indianapolis	Marion
Crockett, F. S.	Lafayette	Tippecanoe	Day, George H.	New Albany	Floyd
Crossland, Steward H.	Gary	Lake	Day, Theodore P.	Willoughby, O.	Vigo
Crowder, James H., Jr.	Sullivan	Sullivan	Day, W. D. C.	Seymour	Jackson
Crum, Marion M.	Angola	Steuben	Deal, Eleanor H.	Speedway City	Marion
Culbertson, C. S.	South Bend	St. Joseph	Dean, Donald I.	Rushville	Rush
Culbertson, Clyde G.	Indianapolis	Marion	Dearmin, R. M.	Indianapolis	Marion
Cullen, P. K.	Indianapolis	Marion	DeArmond, Murray	Indianapolis	Marion
Cullipher, J. E. (H)	Elwood	Madison	Decker, H. B.	Terre Haute	Vigo
Cullnane, C. W.	Evansville	Vanderburgh	DeDario, L. M.	Elkhart	Elkhart
Culloden, William G.	Indianapolis	Marion	Deever, J. W.	Indianapolis	Marion
Culmer, W. N.	Bloomington	Owen- Monroe	DeFries, John J.	New Paris	Elkhart
Culp, John E.	Ft. Wayne	Allen	DeGrazia, E. J.	Valparaiso	Porter
Cummings, D. J.	Brownstown	Jackson	DeLawter, Hilbert H.	Rochester,	Marion
Cunningham, J. M.	Indianapolis	Marion		Michigan	
Cunningham, R. D.	South Bend	St. Joseph	DeLong, C. A. (H)	Gary	Lake
Cure, Elmer T.	Muncie	Delaware- Blackford	DeLong, O. A. (H)	Elizabethtown	Bartholomew - Brown
Currie, Robert W.	Lafayette	Tippecanoe	De Motte, C. Bowen	Indianapolis	Marion
Curry, Claude A.	Terre Haute	Vigo	DeMotte, Russell A.	Bloomington	Owen- Monroe
Curtner, M. L.	Vincennes	Knox	DeNaut, J. F.	Knox	Starke
Custer, E. W.	South Bend	St. Joseph	DeNaut, J. L.	Hamlet	Starke
Cuthbert, F. S.	Kokomo	Howard	Denham, Robert H.	South Bend	St. Joseph
Cuthbert, M. P.	Indianapolis	Marion	Denman, R. D.	Helmer	Steuben
			Denny, Edgar C.	Richmond	Wayne- Union
D			Denny, Forrest L.	Indianapolis	Marion
Dagley, Hubert R.	Columbus	Bartholomew- Brown	Denny, Frank T.	Ladoga	Montgomery
Dahling, C. W.	New Haven	Allen	Denny, Fred C.	Madison	Jefferson
Dailey, J. E.	Terre Haute	Vigo	Denny, J. W.	Indianapolis	Marion
Dainko, A. J.	East Chicago	Lake	Denny, Melvin H.	Rushville	Rush
Dale, J. W.	Chesterton	Porter	Denton, Larkin D.	Greentown	Howard
Dale, Maxwell H.	Connorsville	Fayette- Franklin	Denzer, E. K.	Evansville	Vanderburgh
Daley, Edward H.	Oldenburg	Fayette- Franklin	Denzer, Wm. Oliver	Evansville	Vanderburgh
Dalton, John E.	Indianapolis	Marion	Deppe, Charles F.	Franklin	Johnson
Dalton, Naomi	Bloomington	Owen- Monroe	Derhammer, G. L.	Brookston	Tippecanoe

Name	City	County
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Jagdeeshpur, India	Marion
DeTar, G. B. (H)	Winslow	Pike
Detrick, H. W.	Hammond	Lake
Dettloff, Frederick	Greencastle	Putnam
Deutsch, Wm.	Muncie	Delaware- Blackford
DeVoe, Kenneth	Woodburn	Allen
DeWees, Dwight L.	Indianapolis	Marion
Dewey, Fred N. (H)	Elkhart	Elkhart
Dewey, Geo. W. (H)	Lafayette	Tippecanoe
DeWitt, C. H. (H)	Valparaiso	Porter
Diamond, Leo	Marion	Grant
Diamondstein, Jos.	Calumet City Ill.	Lake
Dian, A. J.	Gary	Lake
Dian, Julia G. Kuznitz	Gary	Lake
Dick, Jack	New Albany	Jasper- Newton
Dickson, D. D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F.	Evansville	Vanderburgh
Dielman, F. C.	Fulton	Fulton
Dierolf, E. J.	Gary	Lake
Dietl, E. L.	South Bend	St. Joseph
Dillman, Carl E.	Corydon	Harrison
Dilts, Robert	Indianapolis	Marion
Dimond, E. Grey	Boston, Mass.	Marion
Dingle, Paul	Richmond	Wayne- Union
Dininger, W. S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion
Dittmer, J. E.	Kouts	Porter
Dittmer, S. E.	Kouts	Porter
Dittmer, Thomas L.	Indianapolis	Porter
Ditton, I. W. (H)	Ft. Wayne	Allen
Dixon, Rex	Anderson	Madison
Dobbs, O. R.	Greencastle	Putnam
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware- Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Dollens, Claude	Oolitic	Lawrence
Dome, H. S.	Tell City	Perry
Donahue, C. M.	Carmel	Hamilton
Donahue, G. R.	Lafayette	Tippecanoe
Donato, Albert M.	Indianapolis	Marion
Donchess, J. C.	Gary	Lake
Donham, William L.	Bicknell	Knox
Donnelly, Everett F.	South Bend	St. Joseph
Donnelly, Robert W.	Dhahran, Arabia	Sullivan
Donovan, S. J.	Michigan City	La Porte
Dorman, W. L.	Indianapolis	Marion
Dorrance, T. O.	Bluffton	Wells
Dorsey, Philip W.	Terre Haute	Vigo
Doty, J. R.	Gary	Lake
Douglas, G. R. (H)	Valparaiso	Porter
Douglas, William T.	Montpelier	Delaware- Blackford
Dowd, Joseph A.	Indianapolis	Marion
Dowell, E. H.	Rockville	Parke- Vermillion
Downard, Leland F.	Gaston	Delaware- Blackford

Name	City	County
Dragoo, Farrol	Middletown	Madison
Drake, John C.	Anderson	Madison
Draper, M. H.	Tampa, Fla.	Allen
Dreyer, Ralph W.	Knightstown	Henry
Dryden, Gale E.	Indianapolis	Marion
Dublin, William B.	Fort Logan, Colo.	Marion
Dubois, Charles C.	Warsaw	Kosciusko
Dubois, F. T. (H)	Liberty	Wayne- Union
Dubois, R. B.	Lafayette	Tippecanoe
Dudding, J. E.	Hope	Bartholomew- Brown
Duemling, Arnold H.	Ft. Wayne	Allen
Dugan, Thomas J.	Indianapolis	Marion
Dugan, Wm. M.	Indianapolis	Marion
Duggan, J. A.	South Bend	St. Joseph
Duke, B. E.	Decatur	Adams
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, F. M.	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Portland	Jay
Dunbar, Colin V.	Indianapolis	Marion
Duncan, J. S.	Gary	Lake
Duncan, Wm. F. (H)	Aurora	Dearborn- Ohio
Dunham, Wilbur F.	Kempton	Tipton
Dunlap, D. Logan	South Bend	St. Joseph
Dunn, F. W.	Muncie	Delaware- Blackford
Dunning, L. M.	Indianapolis	Marion
Dunstone, H. C.	Ft. Wayne	Allen
Dupes, L. E.	Hobart	Lake
Durkee, M. S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
Dutchess, C. T.	Galveston	Cass
Dutton, H. H.	Martinsville	Morgan
DuVall, W. N.	Mishawaka	St. Joseph
Dyar, E. W.	Indianapolis	Marion
Dycus, W. A.	Evansville	Vanderburgh
Dyer, G. W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Marion
Dyke, Richard W.	Indianapolis	Marion
Dykhuisen, T. A.	Frankfort	Clinton

E

Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Louisville, Ky.	Delaware- Blackford
Eastman, J. R., Jr.	Indianapolis	Marion
Eaton, E. R.	Indianapolis	Marion
Eaton, L. D.	Franklin	Johnson
Eaton, M. J.	Lafayette	Tippecanoe
Eberly, K. C.	Ft. Wayne	Allen
Ebert, J. Wayne	Indianapolis	Marion
Eberwein, J. H.	Indianapolis	Marion
Eby, Ida L.	Goshen	Elkhart
Echternacht, A. P.	Crawfordsville	Montgomery
Eckert, Russell A.	Indianapolis	Marion
Edlavitch, B. M.	Ft. Wayne	Allen
Edmondson, R. E.	Terre Haute	Vigo

Name	City	County	Name	City	County
Edmonds, Kendrick	Bedford	Lawrence	Erk, Vernon O.	Richmond	Tippecanoe
Edwards, Bernard	South Bend	St. Joseph	Ernst, Clifford	Indianapolis	Marion
Edwards, Edward T.	Vincennes	Knox	Ernst, H. C. W.	East Chicago	Lake
Edwards, W. F.	New Albany	Floyd	Eshleman, L. H. (H)	Marion	Grant
Egan, B. W.	Logansport	Cass	Estlick, R. E.	Ft. Wayne	Allen
Egan, Sherman	South Bend	St. Joseph	Ettl, Edward I.	Cromwell	Noble
Egbert, Roy	Indianapolis	Marion	Evans, Frederick H.	Indianapolis	Marion
Eggers, E. L.	Hammond	Lake	Evans, Frederick J.	Clinton	Parke- Vermillion
Eggers, H. W.	Hammond	Lake	Evans, Paul V.	Indianapolis	Marion
Egnatz, Nicholas	Hammond	Lake	Evans, R. M.	Russiaville	Howard
Ehrich, W. S.	Evansville	Vanderburgh	Everly, Ralph	Indianapolis	Marion
Ehrman, C. D.	Rockport	Spencer	Eviston, J. B.	Huntington	Huntington
Eicher, Palmer	Indianapolis	Marion	Ewbank, J. Nelson	Richmond	Wayne-Union
Eifert, E. E.	Loogootee	Daviess- Martin	Ewing, Nathaniel D.	Vincennes	Knox
Eickenberry, H. W.	Indianapolis	Marion	F		
Eisaman, C. L.	Marion	Marion	Fagaly, W. J.	Lawrenceburg	Dearborn- Ohio
Eisaman, Jack L.	Bluffton	Wells	Fair, John R.	Wolf Lake	Noble
Eisenberg, D. A.	Martinsville	Morgan	Faith, I. L.	Boonville	Warrick
Eisenlohr, Eugen	Terre Haute	Vigo	Faltin, Ladislaus	South Bend	St. Joseph
Eisterhold, John A.	Evansville	Vanderburgh	Farabee, Charles R.	North Judson	Starke
Eldridge, Gail E.	Indianapolis	Marion	Fargher, F. M.	Michigan City	La Porte
Elledge, Ray	Hammond	Lake	Fargher, R. A.	La Porte	La Porte
Ellerbrook, George E.	Vevay	Switzerland	Farnsworth, Sam A.	La Porte	La Porte
Ellett, John, Jr.	Coatesville	Hendricks	Farr, James	Martinsville	Morgan
Elliott, John C.	Guilford	Dearborn- Ohio	Farrell, J. T.	Indianapolis	Marion
Elliott, L. A.	Elkhart	Elkhart	Farris, John S.	Washington	Daviess- Martin
Elliott, R. A.	Gary	Lake	Farver, M. A.	Middlebury	Elkhart
Elliott, R. H.	Connersville	Fayette- Franklin	Faucett, Ralph E.	San Diego, Calif.	Wayne- Union
Elliott, Thomas A.	New Orleans, La.	Elkhart	Faul, Henry J.	Evansville	Vanderburgh
Ellis, Bert	Indianapolis	Marion	Faulkner, W. H.	Richmond	Wayne- Union
Ellis, Davis W., Jr.	Indianapolis	Marion	Faussett, C. Basil	Indianapolis	Marion
Ellis, George M.	Connersville	Fayette- Franklin	Feerer, Donald J.	Michigan City	La Porte
Ellis, Lyman H.	Lizton	Hendricks	Feldman, Max	South Bend	St. Joseph
Ellis, Seth	Anderson	Madison	Fender, A. H.	Worthington	Greene
Ellison, Alfred	South Bend	St. Joseph	Ferguson, A. N.	Ft. Wayne	Allen
Elshout, Clem H.	LaPorte	LaPorte	Ferguson, John T.	Hamlet	Marion
Elsner, L. W.	Seymour	Jackson	Ferguson, Wm. B.	Lafayette	Marion
Elsten, A. W.	Anderson	Madison	Ferrara, Donald W.	Peru	Miami
Elston, L. W.	Ft. Wayne	Allen	Ferrara, Joseph F.	Indianapolis	Marion
Elston, Ralph W.	Ft. Wayne	Allen	Ferrara, S. J.	Peru	Miami
Emenhiser, Donald C.	New Haven	Allen	Ferrell, Jesse E.	Fortville	Hancock
Emenhiser, John L.	New Haven	Allen	Ferrell, Mars B.	Fortville	Hancock
Emery, Charles B.	Bedford	Lawrence	Ferry, John L.	Whiting	Lake
Emery, Charles H. (H)	Bedford	Lawrence	Ferry, P. W.	Kokomo	Howard
Emhardt, J.W.A.	Indianapolis	Marion	Fessler, G. S.	Rising Sun	Dearborn- Ohio
Emhardt, John T.	Indianapolis	Marion	Fichman, A. M.	Fort Wayne	Allen
Emme, R. W.	Harlan	Allen	Fickas, Dallas	Evansville	Vanderburgh
Endicott, Wayne	Greenfield	Hancock	Filipek, W. J.	South Bend	St. Joseph
Engel, E. L.	Evansville	Vanderburgh	Fipp, August L.	Rome City	Noble
Engeler, J. E.	Lafayette	Tippecanoe	Firestein, Ben	South Bend	St. Joseph
Engle, J. M.	Portland	Jay	Firestein, Ray	South Bend	St. Joseph
Engle, Russell B.	Winchester	Randolph	Fisch, Charles	Indianapolis	Marion
Engleman, H. K.	Georgetown	Floyd	Fischer, Burnell	Gary	Lake
English, H. E.	Rensselaer	Jasper- Newton	Fischer, C. N.	La Porte	La Porte
English, H. M.	Gary	Lake	Fish, C. M.	South Bend	St. Joseph
English, J. P.	South Bend	St. Joseph	Fish, Edson C.	South Bend	St. Joseph
Ensminger, L. A.	Indianapolis	Marion	Fisher, Gerald	Acton	Gibson
Entner, Charles L.	Connersville	Fayette- Franklin	Fisher, Henry	Marion	Grant
Enzor, O. K.	Indianapolis	Marion	Fisher, John E.	Attica	Fountain- Warren
Episcopo, A. R.	Salem	Washington	Fisher, John E.	Indianapolis	Marion
Erdel, Milton W.	Frankfort	Clinton	Fisher, Lawrence F.	South Bend	St. Joseph
Erehart, A. D.	Anderson	Madison	Fisher, Pierre J.	Marion	Grant
Erehart, M. G.	Huntington	Huntington	Fisher, Seymour	Indianapolis	Marion
Ericksen, Lester G.	South Bend	St. Joseph	Fisher, Walter S.	Columbus	Bartholomew- Brown
Ericson, H. L.	Windfall	Tipton			

Name	City	County
Fisher, Warren E.	Anderson	Madison
Fisher, William C.	Evansville	Vanderburgh
Fisk, Frank B.	Indianapolis	Marion
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, H. W.	Elwood	Madison
Fitzsimmons, E. L.	Evansville	Vanderburgh
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Walter T.	Michigan City	LaPorte
Flanagan, E. P.	Walton	Cass.
Flanigan, M. B.	Indianapolis	Marion
Flannigan, H. F.	Lagrange	Lagrange
Fleetwood, R. A.	Nappanee	Elkhart
Fleischer, J. C.	East Chicago	Lake
Fleming, C. F.	Elkhart	Elkhart
Fleming, Justus M.	Elkhart	Elkhart
Fletcher, Charles F.	Sunman	Dearborn- Ohio
Flick, John J.	Indianapolis	Marion
Flinn, John H.	Evansville	Vanderburgh
Flora, Joseph O.	Indianapolis	Marion
Folck, J. K.	Princeton	Gibson
Folkening, N. C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Forbes, Violet Crabbe	Wolcott	Tippecanoe
Foreman, Harry L.	Indianapolis	Marion
Foreman, Walter A.	Brookville	Fayette- Franklin
Forry, Frank	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Forster, N. K.	Pacific Palisades, Calif.	Lake
Foster, Ray T.	Indianapolis	Marion
Forsyth, D. H.	Terre Haute	Vigo
Fosbrink, E. L.	Syracuse	Elkhart
Fosler, D. W.	Indianapolis	Marion
Fountaine, Thomas J.	Bedford	Lawrence
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Petersburg	Pike
Fox, C. Philip	Washington	Daviess- Martin
Fox, M. S.	Vincennes	Knox
Fox, R. H.	Bicknell	Knox
Foy, H. W.	Ft. Wayne	Allen
Frank, J. R.	Valparaiso	Porter
Frank, L. L.	South Bend	St. Joseph
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Danville	Hendricks
Frasch, M. G.	Lafayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Frazin, Bernard	Indianapolis	Marion
Freed, Carl A.	Attica	Fountain- Warren
Freed, James C.	Attica	Fountain- Warren
Freed, John E., Sr.	Terre Haute	Vigo
Freed, John E., Jr.	Chicago, Ill.	Vigo
Freeman, F. M.	Goshen	Elkhart
Freeman, Joseph W.	Denver, Colo.	Henry
French, Wm. G.	Evansville	Vanderburgh
Friedman, Herbert P.	Urbana, Ill.	Marion
Friedman, Isadore E.	Hammond	Lake
Friedman, Leo	Evansville	Vanderburgh
Friedman, Morris S.	South Bend	St. Joseph
Frith, Gladys D.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fritsch, L. E.	Evansville	Vanderburgh
Fromhold, Willis A.	Indianapolis	Marion
Frost, Robert J.	South Bend	St. Joseph
Fry, Robert D.	Indianapolis	Marion

Name	City	County
Frybarger, S. S.	Converse	Miami
Fullerton, R. L.	Indianapolis	Marion
Funk, John W.	Muncie	Delaware- Blackford
Funkhouser, A. G.	Indianapolis	Marion
Funkhouser, Elmer	Indianapolis	Marion
Fuqua, Harold B.	Terre Haute	Vigo
Furgason, Paul C.	Indianapolis	Marion
Furniss, S. A.	Indianapolis	Marion
Fuson, W. J.	Greencastle	Putnam
G		
Gabe, Wm. E.	Indianapolis	Marion
Gable, H. B.	Monticello	White
Gaddy, Euclid T.	Indianapolis	Marion
Galante, Vincent J.	Gary	Lake
Galbreath, R. S.	Huntington	Huntington
Galbreath, J. P.	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware- Blackford
Gallup, Palmer R.	Indianapolis	Marion
Gambill, Wm. D.	Indianapolis	Marion
Gammieri, Robert L.	Indianapolis	Marion
Gannon, G. W.	Gary	Lake
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, H. W.	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, E. C.	Dunkirk	Jay
Garber, J. Neill	Indianapolis	Marion
Garber, Paul A.	South Whitley	Whitley
Garceau, George J.	Indianapolis	Marion
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Buchman	Indianapolis	Marion
Gardner, M. D.	Michigan City	LaPorte
Gardner, Russell A.	Michigan City	LaPorte
Garfield, M. D.	Indianapolis	Marion
Garland, Edgar	Evansville	Vanderburgh
Garling, L. C.	Muncie	Delaware- Blackford
Garner, William	Indianapolis	Marion
Garner, W. Stanley	Indianapolis	Marion
Garner, Wm. H.	New Albany	Floyd
Garrett, John D. (H)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Marion
Garrison, Leon J.	Gas City	Grant
Garton, H. W.	Ft. Wayne	Allen
Gastineau, F. M.	Indianapolis	Marion
Gatch, W. D.	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Gehres, R. W.	Shelbyville	Shelby
Geick, Raymond	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon	Bloomington	Owen- Monroe
Geisinger, L. N.	Auburn	De Kalb
Geller, Samuel	Indianapolis	Marion
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Gerrish, D. A.	Terre Haute	Vigo
Gerrish, W. D.	Clinton	Parke- Vermillion
Gery, Richard E.	Lafayette	Tippecanoe
Gessler, W. F.	Fort Wayne	Allen
Gevirtz, M. B.	Hammond	Lake
Gibbs, Charles	Greenfield	Hancock
Gibbs, Joseph W.	Danville	Hendricks
Gibson, Greta	Indianapolis	Marion
Gibson, J. J. (H)	Alexandria	Madison
Gick, Herman	Indianapolis	Marion

Name	City	County	Name	City	County
Gifford, F. E.	Indianapolis	Marion	Graf, John P.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo	Graf, Jerome A.	Bloomfield	Greene
Gill, B. P.	Evansville	Vanderburgh	Graham, George M.	Ft. Wayne	Allen
Gill, D. D.	Greenfield	Hancock	Graham, Thomas	Lafayette	Tippecanoe
Gill, Thomas A.	Muncie	Delaware- Blackford	Grant, Benjamin F.	Gary	Lake
Gillespie, C. E.	Seymour	Jackson	Grant, John	Cynthiana	Posey
Gillespie, C. F.	Indianapolis	Marion	Graves, J. W.	Indianapolis	Marion
Gillespie, G. R.	Brownstown	Jackson	Graves, Orville M.	Princeton	Gibson
Gillespie, J. E.	Indianapolis	Marion	Gray, Clyde C.	Cloverdale	Putnam
Gillespie, J. F. (H)	Greencastle	Putnam	Gray, D. E.	Crown Point	Lake
Gilliatt, J. P.	Salem	Washington	Gray, Leon	Martinsville	Morgan
Gillum, John R.	Terre Haute	Vigo	Gray, Paul M.	Huntington	Huntington
Gilman, M. M.	South Bend	St. Joseph	Grayston, F. W. (H)	Huntington	Huntington
Gilmore, L. L.	Vincennes	Knox	Grayston, Wallace S.	Huntington	Huntington
Gilmore, R. A.	Michigan City	LaPorte	Green, Carl L.	Vincennes	Knox
Gingerick, C. M.	Liberty Center	Wells	Green, F. H., Jr.	Rushville	Rush
Ginsberg, Stewart	Marion	Grant	Green, George F.	South Bend	St. Joseph
Giordano, A. S.	South Bend	St. Joseph	Green, Harrison	Indianapolis	Marion
Girod, Arthur H.	Decatur	Adams	Green, John H.	North Vernon	Jennings
Gitlin, Max M.	Bluffton	Wells	Green, Oscar	Indianapolis	Marion
Gitlin, Wm. A.	Bluffton	Wells	Green, S. I.	St. Bernice	Parke- Vermillion
Givner, David,	Indianapolis	Marion	Green, Wm. L.	Pekin	Washington
Glackman, J. C., Jr.	Rockport	Spencer	Greene, Claude D.	Spencer	Owen-Monroe
Glackman, J. C., Sr.	Rochester	Fulton	Greene, F. G.	Bloomington	Parke- Vermillion
Gladstone, N. H.	Fort Wayne	Allen	Gregg, Albert F.	Connersville	Fayette- Franklin
Glaser, E. M.	Brookville	Fayette- Franklin	Gregg, Edwin E.	Thorntown	Boone
Glaser, Robert E.	Brookville	Fayette- Franklin	Greiber, Marvin F.	Muncie	Delaware- Blackford
Glass, R. L.	Indianapolis	Marion	Greist, H. W. (H)	Monticello	White
Glendening, J. L.	Indianapolis	Marion	Greist, John	Indianapolis	Marion
Glenn, Fred C.	Tell City	Perry	Greip, Arthur H.	Evansville	Vanderburgh
Glenn, L. F.	Ramsey	Harrison	Griffin, J. P.	Chesterton	Porter
Glick, O. E.	Kentland	Jasper- Newton	Griffis, V. C.	Richmond	Wayne- Union
Glock, H. E.	Fort Wayne	Allen	Griffith, James W.	Sheridan	Hamilton
Glock, M. E.	Fort Wayne	Allen	Griffith, R. E.	Indianapolis	Marion
Glock, Wayne R.	Fort Wayne	Allen	Grillo, Donald	South Bend	St. Joseph
Glosson, Jack R.	Clay City	Clay	Grimes, J. H.	Martinsville	Hendricks
Goad, Lloyd H.	Gary	Lake	Grisell, Ted L.	Indianapolis	Marion
Gobbel, N. E.	English	Crawford	Grissom, Robert L.	Michigan City	LaPorte
Godwin, J. David	San Diego, Calif.	Hancock	Griswold, W. R.	Mare Island, Calif.	Marion
Goethals, Charles J.	Mishawaka	St. Joseph	Gros, Hubert	Delphi	Carroll
Goldberg, Harold B.	Gary	Lake	Grosskreutz, Doris	Evansville	Vanderburgh
Goldman, Samuel	Indianapolis	Marion	Grossman, W. L.	North Vernon	Jennings
Goldstone, Adolph	Gary	Lake	Grossnickle, Geo. W.	Elkhart	Elkhart
Goldstone, Joseph	Gary	Lake	Grosso, W. G.	East Chicago	Lake
Goldstone, S. R.	Gary	Lake	Grove, Robert H.	Rossville	Clinton
Good, R. P.	Kokomo	Howard	Gudenkauf, E. B.	Clarksville	Clark
Goodman, Eli	Charlestown	Clark	Gullett, Charles C.	Union City	Randolph
Goodman, H. T.	Terre Haute	Vigo	Gustafson, G. W.	Indianapolis	Marion
Goodrich, Albert	New York, N. Y.	Marion	Gustafson, Milton	Muncie	Delaware- Blackford
Goodwin, C. B. (H)	Kendallville	Noble	Gustaitis, John W.	East Chicago	Lake
Goodwin, Caroline M.	Indianapolis	Marion	Gutelius, C. B.	Indianapolis	Marion
Goraczewski, Thaddeus	South Bend	St. Joseph	Guthrie, F. C.	Anderson	Madison
Gordin, Stanley	Connersville	Fayette- Franklin	Gutierrez, F. A.	Gary	Lake
Gordin, Stanton E. (H)	Connersville	Fayette- Franklin	Gutstein, Richard R.	Kendallville	Noble
Gordon, J. L.	Wheeler	Porter	Gwaltney, L. F.	Roachdale	Putnam
Gordon, J. M.	South Bend	St. Joseph	Gwin, M. D.	Miami Beach, Fla.	Jasper- Newton
Gorton, Mary L.	Gary	Lake	Gwinn, John L.	Corydon	Harrison
Gosman, James H.	Indianapolis	Marion			
Gossard, Meredith B.	Tipton	Knox		H	
Gould, L. K.	Ft. Wayne	Allen	Habegger, Myron L.	Berne	Adams
Goux, Warren	Evansville	Vanderburgh	Habich, Carl	Indianapolis	Marion
Govorchin, Alexander	East Chicago	Lake	Hack, E. C.	Hammond	Lake
Graessle, Harold P.	Seymour	Jackson	Hadden, Claude E.	Indianapolis	Marion
Graf, John E.	Chicago, Ill.	Marion	Hade, Frederick L.	Bridgeport	Marion

Name	City	County	Name	City	County
Hadley, David	Indianapolis	Marion	Harris, B. W.	Lake Wales, Fla.	Lake
Hadley, Harvey	Richmond	Wayne-Union	Harris, Carl B.	Indianapolis	Marion
Hadley, Murray N.	Indianapolis	Marion	Harris, Donald M.	Gary	Lake
Haffner, H. G.	Ft. Wayne	Allen	Harrison, Wm. H. (H)	Kokomo	Howard
Haggard, E. B.	Indianapolis	Marion	Harris, Paul N.	Indianapolis	Marion
Hagie, F. E.	Richmond	Wayne-Union	Harris, R. F.	Noblesville	Hamilton
Hahn, E. V.	Indianapolis	Marion	Harris, Wm. Lee	Evansville	Vanderburgh
Haley, Paul E.	South Bend	St. Joseph	Harshman, L. P.	Ft. Wayne	Allen
Hall, Bernard R.	Logansport	Cass	Harshman, Martin L.	Lafayette	Tippecanoe
Hall, E. H.	Dunkirk	Delaware-Blackford	Harstad, C.	Rockville	Parke-Vermillion
Hall, Frank M.	Indianapolis	Marion	Hart, L. Paul	Evansville	Vanderburgh
Hall, Jack R.	Indianapolis	Marion	Hart, Robert B.	Columbus	Bartholomew-Brown
Hall, O. A.	Muncie	Delaware-Blackford	Hart, Wm. D.	Anderson	Madison
Hall, T. C.	Chesterton	Porter	Harter, Eli Blair	Lafayette	Tippecanoe
Hallam, F. T.	Indianapolis	Marion	Hartley, C. A., Jr.	Evansville	Vanderburgh
Halleck, H. J.	Winamac	Pulaski	Hartley, C. A. (H)	Evansville	Vanderburgh
Haller, Robert L.	Churubusco	Whitley	Hartz, F. Minton	Evansville	Vanderburgh
Haller, Thomas C.	Crawfordsville	Montgomery	Harvey, Bennett B.	Kokomo	Howard
Hamer, H. G.	Indianapolis	Marion	Harvey, Harry C.	Ft. Wayne	Allen
Hamilton, Antha A.	Shelburn	Sullivan	Harvey, R. J.	Zionsville	Boone
Hamilton, Charles O.	South Bend	St. Joseph	Harvey, Verne K.	Alexandria, Va.	Marion
Hamilton, Emory D.	Ft. Wayne	Allen	Hasewinkle, A. M.	Ft. Wayne	Allen
Hamilton, Guy W.	Madison	Jefferson	Hash, John S.	Noblesville	Hamilton
Hamilton, J. R.	Mitchell	Lawrence	Haskell, Cosa D.	San Francisco, Calif.	Marion
Hamilton, M. Luther	Newberry	Greene	Haslem, Ezra R.	Terre Haute	Vigo
Hamilton, O. G.	Bluffton	Wells	Haslem, John R.	Terre Haute	Vigo
Hamilton, R. C.	East Chicago	Lake	Hasler, Norman B.	Indianapolis	Marion
Hammel, Howard T.	Bedford	Lawrence	Haslinger, C. J.	Indianapolis	Marion
Hammer, Jay Wm.	Middletown	Delaware-Blackford	Hastings, Warren C.	Ft. Wayne	Allen
Hammersley, Geo. K.	Frankfort	Clinton	Hatfield, B. F.	Indianapolis	Marion
Hammond, Keith	Paoli	Orange	Hatfield, Jack J.	Indianapolis	Marion
Hammond, Ruben C.	Indianapolis	Marion	Hatfield, N. W.	Indianapolis	Marion
Hammond, Stanley M.	Portland	Jay	Hathaway, Clayton B.	Butler	DeKalb
Hampshire, Don R.	Indianapolis	Marion	Hattendorf, A. P.	Ft. Wayne	Allen
Hancock, John G.	Indianapolis	Marion	Hauss, Augustus P.	New Albany	Floyd
Handelman, Eugene	Hammond	Lake	Havens, Oscar	Cicero	Hamilton
Hanley, Marshall J.	Jamaica, N. Y.	Marion	Havens, R. E.	Ft. Wayne	Allen
Hanna, T. A.	Indianapolis	Marion	Havice, Jay F.	Lake Lure, N. C.	Allen
Hannah, Jack W.	Wakarusa	Elkhart	Hawes, M. E.	Columbus	Bartholomew-Brown
Hansell, R. M.	Indianapolis	Marion	Hawk, Edgar	Greenefield	Hancock
Hansen, A. H.	Hammond	Lake	Hawk, James H.	Indianapolis	Marion
Hanson, Martin F.	Elwood	Madison	Hayes, Jess D.	East Chicago	Lake
Harcourt, A. K.	Indianapolis	Marion	Hayes, T. R.	Muncie	Delaware-Blackford
Harden, Murray E.	Indianapolis	Fountain-Warren	Haymond, George N.	Warsaw	Kosciusko
Hardin, W. E.	Ossian	Wells	Haymond, Joseph L.	Indianapolis	Marion
Harding, M. Richard	Indianapolis	Marion	Hays, E. L.	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion	Hays, George R.	Richmond	Wayne-Union
Hardy, Chas. F. (H)	Kendallville	Noble	Hazel, James T. (H)	Freedom	Owen-Monroe
Hardy, John J.	North Liberty	St. Joseph	Hazinski, R. T.	Griffith	Lake
Hare, Daniel M.	Evansville	Vanderburgh	Headley, L. M.	Lebanon	Boone
Hare, E. H.	Indianapolis	Marion	Healy, Wm. F.	Evansville	Vanderburgh
Hare, John H.	Evansville	Vanderburgh	Heard, Albert	Evansville	Vanderburgh
Hare, Laura	Indianapolis	Marion	Heberer, J. M.	Evansville	Vanderburgh
Harger, Robert W.	Indianapolis	Marion	Heck, M. C.	Jasper	Dubois
Hargis, W. T. (H)	Tell City	Perry	Hedde, E. L.	Logansport	Cass
Harkness, R. G.	Terre Haute	Vigo	Hedgcock, R. A.	Frankfort	Clinton
Harlan, William L.	Cromwell	Noble	Hedrick, Philip W.	Indianapolis	Marion
Harless, Clarence M.	Chesterton	Porter	Hefti, Karl	Evansville	Vanderburgh
Harmon, C. J.	Richmond	Wayne-Union	Heilman, W. C.	New Castle	Henry
Harmon, Gladys H.	Richmond	Wayne-Union	Heinrich, H. H.	Indianapolis	Marion
Harmon, Vachelle E.	South Bend	St. Joseph	Heinrich, Weston A.	Evansville	Vanderburgh
Harmon, Wayne	Lynn	Randolph	Heinz, Dorothy C. V.	Indianapolis	Marion
Harold, A. H.	Indianapolis	Marion			
Harold, N. E. (H)	Indianapolis	Marion			

Name	City	County	Name	City	County
Held, George A.	Jasper	Dubois	Himebaugh, Gilbert	Veedersburg	Fountain-Warren
Heller, N. L.	Dunkirk	Jay	Himebaugh, J. R. S.	Indianapolis	Marion
Heller, Oscar (H)	Greenfield	Hancock	Himler, James M.	Indianapolis	Marion
Helmen, H. W.	South Bend	St. Joseph	Hinchman, C. P.	Geneva	Adams
Helper, Morton	Evansville	Vanderburgh	Hinchman, Jean F.	Parker	Delaware-Blackford
Henderson, Arvin	Ridgeville	Randolph	Hine, Ullis B.	Indianapolis	Marion
Henderson, N. C.	Michigan City	LaPorte	Hines, A. V.	Auburn	DeKalb
Henderson, R. A.	Muncie	Delaware-Blackford	Hines, Don C.	Indianapolis	Marion
Hendricks, John D.	Indianapolis	Marion	Hinkson, George D.	Gary	Lake
Hendricks, John W.	Indianapolis	Marion	Hippensteel, R. R.	Indianapolis	Marion
Henley, Glenn	Fairmount	Grant	Hisrich, L. W.	Batesville	Ripley
Hennessee, Philip C.	Portland	Jay	Hobbs, Arthur	Evansville	Vanderburgh
Henning, Carl	Hanover	Jefferson	Hochhalter, Marion	Logansport	Cass
Henry, Alvin L.	Indianapolis	Marion	Hodges, Fletcher	Indianapolis	Marion
Henry, Howard J.	Knox	Starke	Hodges, Wm. A.	Oaktown	Knox
Henry, Russell S.	Indianapolis	Marion	Hodgin, Phillip	Orleans	Lawrence
Hensler, B. M.	Anderson	Madison	Hodurski, Zigfield	Gary	Lake
Hepburn, C. K.	Indianapolis	Marion	Hoeger, H. R.	Brookville	Fayette-Franklin
Hepner, H. S.	Bloomington	Owen-Monroe	Hoetzer, Eldore M.	New Haven	Allen
Hepner, Ruth	Oahu, T. H.	Owen-Monroe	Hofferkamp, A. G.	New Albany	Floyd
Herd, Cloyd R.	Peru	Miami	Hoffman, A. F.	Ft. Wayne	Allen
Hendendeen, E. V.	Rochester	Fulton	Hoffman, Curtis R.	Richmond	Wayne-Union
Heritier, Jules	Columbia City	Whitley	Hoffman, Doris	Vincennes	Knox
Herr, John W.	Mount Vernon	Posey	Hoffman, Herman	Hartford City	Delaware-Blackford
Herrick, C. L.	Akron	Fulton	Hoffman, R. V.	South Bend	St. Joseph
Herring, G. N.	Pierceton	Kosciusko	Hoffmann, S. P., Sr.	Ft. Wayne	Allen
Herrmann, Gordon T.	Indianapolis	Marion	Hofmann, Andrew	Hammond	Lake
Herrold, G. W.	Lafayette	Tippecanoe	Hofmann, J. Wm.	Indianapolis	Marion
Hershey, E. A.	Churubusco	Whitley	Hogle, Frank D.	Logansport	Marshall
Herzer, C. C.	Evansville	Vanderburgh	Holdeman, Lillian	South Bend	St. Joseph
Hetherington, A. M.	Indianapolis	Marion	Holdeman, R. W.	South Bend	St. Joseph
Hetherington, John A.	Rochester, Minn.	Marion	Holladay, L. J.	Lafayette	Tippecanoe
Hetman, Mitchell J.	Westville	LaPorte	Holland, Chas. E.	Bloomington	Owen-Monroe
Heubi, John E.	Indianapolis	Marion	Holland, D. J.	Bloomington	Owen-Monroe
Hewitt, M. I.	South Bend	St. Joseph	Holland, E. E.	Richmond	Wayne-Union
Hewlett, Thomas H.	Philadelphia, Pa.	Floyd	Holland, Philip	Bloomington	Owen-Monroe
Heysett, Norman W.	Ft. Wayne	Allen	Holliday, L. D.	Fairmount	Grant
Hiatt, R. L.	Washington, D. C.	Wayne-Union	Hollingsworth, A. A.	Indianapolis	Marion
Hibner, Nolan A.	Monticello	White	Hollingsworth, Marshall P. (H)	Princeton	Gibson
Hickman, A. Lee	Hammond	Lake	Hollis, Walter H.	Indianapolis	Marion
Hickman, W. R.	Logansport	Cass	Holloway, W. A. (H)	Logansport	Cass
Hickman, Walter	Indianapolis	Marion	Holman, J. E., Sr.	Indianapolis	Marion
Hicks, Joseph (H)	Arcadia	Hamilton	Holman, J. E., Jr.	Indianapolis	Marion
Hiestand, H. J.	Pennville	Jay	Holmes, Claude D.	Frankfort	Clinton
Higbee, Paul	Sullivan	Sullivan	Holmes, Claude D., Sr.	Frankfort	Clinton
Higgins, James L.	Otwell	Pike	Holmes, G. W.	Chicago, Ill.	Lake
Higgins, O. C.	Lebanon	Boone	Holmes, W. W.	Logansport	Cass
High, Ralph L.	Muncie	Delaware-Blackford	Holsinger, R. E.	Ft. Wayne	Allen
Hilbert, John W.	South Bend	St. Joseph	Holtzendorf, C. E. (H)	St. Petersburg, Fla.	Marshall
Hildebrand, W. O.	Topeka	Lagrange	Holtzman, Paul W.	Bluffton	Wells
Hill, Edward C.	Indianapolis	Marion	Honan, Paul R.	Lebanon	Boone
Hill, H. D.	Richmond	Wayne-Union	Hood, Ainslee A.	Indianapolis	Marion
Hill, H. E.	Muncie	Delaware-Blackford	Hooke, Sam W.	Noblesville	Hamilton
Hill, Kenneth G.	New Castle	Henry	Hoopes, Jane	Evansville	Vanderburgh
Hill, Paul G.	Cambridge City	Wayne-Union	Hoover, D. A.	Terre Haute	Vigo
Hill, Robert	Muncie	Delaware-Blackford	Hoover, J. Guy	Boonville	Warrick
Hill, T. N.	Scottsburg	Scott	Hoover, J. J.	Terre Haute	Vigo
Hilldrup, Don G.	Fort Sill, Okla.	Marion	Hoover, Peter B.	Boonville	Warrick
Hillenbrand, Charles	Michigan City	LaPorte	Hopkins, S. R.	Hammond	Lake
Hillery, J. L.	Warsaw	Kosciusko	Hopkins, Lester H.	Versailles	Ripley
Hillis, L. J.	Logansport	Cass	Hoppenrath, W. M.	Elwood	Madison
Hillman, Marion W.	South Bend	St. Joseph	Hoppenrath, Wm. (H)	Elwood	Madison
Hillman, W. H.	South Bend	St. Joseph	Hornaday, W. A.	Evansville	Lake
Hillsamer, Phyllis	W. Lafayette	Tippecanoe	Horst, William N.	Crown Point	Lake

Name	City	County
Horswell, R. G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Horton, George R.	Ft. Wayne	Allen
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware- Blackford
Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	Tippecanoe
Houseworth, John H.	Indianapolis	Marion
Housley, J. L.	Ft. Wayne	Allen
Houston, Fred D.	Lawrenceburg	Dearborn- Ohio
Howell, Joseph D.	Indianapolis	Marion
How, John T. (H)	Lakeville	St. Joseph
How, Louis E.	Lakeville	St. Joseph
Howard, W. H.	Hammond	Lake
Howe, Fordyce L.	Ft. Wayne	Allen
Howell, R. D.	Indianapolis	Marion
Hoyt, Lester H.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Carl D.	Danville	Hendricks
Huckleberry, Irvin	Salem	Washington
Hudson, Foster J.	Indianapolis	Marion
Huff, A. D.	Marion	Grant
Huffman, A. D.	South Bend	St. Joseph
Huffman, V. P.	South Whitley	Whitley
Hufnagel, C. A.	Richmond	Wayne- Union
Huggins, Victor S.	Evansville	Vanderburgh
Hughes, J. E.	Indianapolis	Marion
Hughes, L. M.	Paragon	Morgan
Hughes, Richard R.	Indianapolis	Marion
Hughes, W. F. (H)	Indianapolis	Marion
Hull, A. W.	Elkhart	Elkhart
Hull, James E.	Columbia City	Marion
Hummel, R. M.	Marion	Grant
Hummons, Henry L.	Indianapolis	Marion
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John W.	Crawfordsville	Montgomery
Hunn, M. F.	Elkhart	Elkhart
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne- Union
Hunter, F. P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Milan	Ripley
Huoni, J. S.	Jeffersonville	Clark
Hupe, Charles (H)	Lafayette	Tippecanoe
Hurley, Anson	Muncie	Delaware- Blackford
Hurley, John R.	Daleville	Delaware- Blackford
Hursey, Virgil G.	Milford	Kosciusko
Hurst, E. M.	Cloverdale	Putnam
Hurt, L. B.	Indianapolis	Marion
Hurt, Paul T.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert	Hammond	Lake
Hutcheson, W. R.	Greencastle	Putnam
Hutchinson, B. M.	Mishawaka	St. Joseph
Hutto, W. H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll	South Bend	St. Joseph
Hynes, Roy	Indianapolis	Marion

I

Iddings, J. W.	Crown Point	Lake
Ikins, R. G.	Lafayette	Tippecanoe
Imhof, Joseph D.	Muncie	Delaware- Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert	Shelbyville	Shelby
Inlow, W. D.	Shelbyville	Shelby
Irey, P. R.	Plymouth	Marshall
Irish, Wilbur	East Chicago	Lake

Name	City	County
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth	Summitville	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, N. C.	Jeffersonville	Clark
Iterman, G. E.	New Castle	Henry
Ives, R. J.	Francesville	Pulaski

J

Jackson, Dean B.	Hartford City	Delaware- Blackford
Jackson, F. E.	Indianapolis	Marion
Jackson, John F.	Bluffton	Wells
Jackson, J. K.	Aurora	Dearborn- Ohio
Jackson, J. L.	Indianapolis	Marion
Jackson, J. W.	Indianapolis	Marion
Jacobs, H. A.	Indianapolis	Marion
Jaeger, A. S.	Indianapolis	Marion
James, N. A.	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, M. C.	Gary	Lake
Jaquith, O. S. (H)	Indianapolis	Marion
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jay, Robert	Honolulu, Hawaii	Marion
Jeffries, K. I.	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jenkinson, W. E.	Lowell, Mass.	Posey
Jennings, Frank	Indianapolis	Marion
Jewell, Earl B.	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jewett, Lawrence (H)	Indianapolis	Wabash
Jewett, Robert E.	Indianapolis	Marion
Jinks, C. H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	DeKalb
Jobs, James E.	Indianapolis	Marion
Jobs, N. E. (H)	Indianapolis	Marion
Joest, Charles O.	Mishawaka	St. Joseph
Johns, D. R.	East Chicago	Lake
Johns, Elmer D.	Zionsville	Boone
Johns, N. C.	Argos	Marshall
Johnson, C. E.	Rensselaer	Jasper- Newton
Johnson, E. N.	Sandborn	Knox
Johnson, Earl E.	Covington	Fountain- Warren
Johnson, F. D.	Waynetown	Montgomery
Johnson, G. C. (H)	Evansville	Vanderburgh
Johnson, James B.	Greencastle	Putnam
Johnson, J. J.	Milltown	Crawford
Johnson, J. M.	Palmyra	Harrison
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, M. H. C.	Vincennes	Knox
Johnson, Paul Dewey	Terre Haute	Vigo
Johnson, Paul S.	Richmond	Wayne- Union
Johnson, R. B.	Rushville	Rush
Johnson, S. L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, W. A.	Perrysville	Parke- Vermillion
Johnson, Wm. F.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks
Johnston, D. D.	Indianapolis	Allen
Johnston, Robert L.	Bluffton	Wells
Johnston, R. G.	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson
Jolly, W. P.	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Charles A.	Franklin	Johnson
Jones, Clifford M.	Whiting	Lake

Name	City	County	Name	City	County
Jones, D. D. (H)	Berne	Adams	Kempf, G. F.	Indianapolis	Marion
Jones, David	Lafayette	Tippecanoe	Kendall, F. M.	Nappanee	Elkhart
Jones, David E.	Indianapolis	Marion	Kendrick, Frank J.	Gary	Lake
Jones, E. S.	Hammond	Lake	Kendrick, W. M.	Indianapolis	Marion
Jones, Francis P.	Indianapolis	Marion	Kennedy, Eva	Camden	Carroll
Jones, George	Wanamaker	Marion	Kennedy, Hall	Indianapolis	Marion
Jones, H. E.	Anderson	Madison	Kennedy, H. F.	Indianapolis	Marion
Jones, John C.	LaPorte	LaPorte	Kennedy, R. O.	Rushville	Rush
Jones, John Carl	Logansport	Cass	Kennedy, W. U.	New Castle	Henry
Jones, King Solomon	Michigan City	LaPorte	Kenney, Francis D.	Hammond	Lake
Jones, R. B.	LaPorte	LaPorte	Kent, J. A.	Mulberry	Clinton
Jones, W. W.	Frankfort	Clinton	Kent, Richard N.	Ft. Wayne	Allen
Jordan, Leo E.	Lynn	Randolph	Kenyon, C. E.	Cambridge	Wayne- Union
Joseph, Herbert L.	St. Louis, Mo.	Marion	Kenoyer, Wilbur L.	Ft. Knox, Ky.	Marion
Joseph, Rex M.	Indianapolis	Marion	Kepler, R. W.	La Porte	LaPorte
Josif, Lazar	Santa Barbara, Calif.	Lake	Kern, C. B. (H)	Muncie	Delaware- Blackford
Jump, Charles A.	Selma	Delaware- Blackford	Kern, C. G.	Lebanon	Boone
Jurgensen, Walter T.	Ft. Wayne	Allen	Kerr, A. R.	Attica	Fountain- Warren
K			Kerr, Charles M.	Indianapolis	Marion
Kabel, Robert N.	Terre Haute	Marion	Kerr, Harry R.	Indianapolis	Marion
Kahan, H. L.	Gary	Lake	Kerrigan, R. L.	Michigan City	LaPorte
Kahler, M. V.	Indianapolis	Marion	Kerrigan, William F.	Evansville	Vanderburgh
Kahn, Alexander J.	Indianapolis	Marion	Keseric, Nicholas E.	French Lick	Orange
Kahn, Howard L.	Indianapolis	Marion	Kessler, Robert B.	Evansville	Vanderburgh
Kalb, Everett L.	Indianapolis	Marion	Ketcham, Jane M.	Indianapolis	Marion
Kaler, James	Plymouth	Marshall	Ketcham, John S.	Rossville	Clinton
Kamm, Bernard A.	South Bend	St. Joseph	Kidd, James G.	Roann	Wabash
Kamman, G. H. (H)	Seymour	Jackson	Kidder, J. J. (H)	Salamonia	Jay
Kammen, Leo	Indianapolis	Marion	Kidder, Orva T.	Ft. Wayne	Allen
Kammen, Robert	Indianapolis	Marion	Kiechle, Frederick L.	Evansville	Vanderburgh
Kammer, Grace C.	Muncie	Delaware- Blackford	Kilgore, Byron, Jr.	Indianapolis	Marion
Kammer, Walter F.	Muncie	Delaware- Blackford	Killough, Aimee R.	Michigan City	LaPorte
Kantzer, Floyd B.	Garrett	DeKalb	Kim, Young D.	Beech Grove	Marion
Karn, John W.	South Bend	St. Joseph	Kime, Charles E.	Richmond	Wayne- Union
Karberg, Richard J.	Lafayette	Tippecanoe	Kime, E. N.	Indianapolis	Marion
Karpel, Bernard	Mooreville	Morgan	Kime, J. T. (H)	Petersburg	Pike
Karsell, W. A.	Bloomington	Owen- Monroe	Kindell, H. D.	New Richmond	Montgomery
Katterjohn, James C.	Indianapolis	Marion	King, B. A.	Anderson	Madison
Kauffman, H. M.	Evansville	Vanderburgh	King, Dale	Ridgeville	Randolph
Kauffman, Nelson N.	Indianapolis	Marion	King, Everett A.	Evansville	Vanderburgh
Kauffman, Sidney A.	Indianapolis	Marion	King, James R.	Silver Lake	Kosciusko
Kay, Oran	Spencer	Owen- Monroe	King, Joseph W.	Anderson	Madison
Keefe, Thomas L.	Logansport	Cass	King, M. O.	Rochester	Fulton
Keeling, F. E.	Portland	Jay	King, P. C.	Swayzee	Grant
Keenan, R. L.	Indianapolis	Marion	King, Robert W.	Cedar Lake	Lake
Keever, C. H.	Indianapolis	Marion	King, William F.	Indianapolis	Marion
Keiser, V. D.	Indianapolis	Marion	Kingsbury, J. K.	Indianapolis	Marion
Keith, F. E. (H)	St. Bernice	Parke- Vermillion	Kinnaman, H. A.	Crawfordsville	Montgomery
Keller, F. G. (H)	Alexandria	Madison	Kinneman, R. E.	Greenfield	Hancock
Kelley, Clement E.	Indianapolis	Marion	Kintner, Burton E.	Elkhart	Elkhart
Kelly, Don E.	Indianapolis	Marion	Kinzel, Robert J. W.	Indianapolis	Marion
Kelly, F. H.	Argos	Marshall	Kinzie, M. Dale	Goshen	Elkhart
Kelly, J. F.	Indianapolis	Marion	Kirch, L. N.	Evansville	Vanderburgh
Kelly, J. N.	La Porte	LaPorte	Kirklin, Oren L.	Indianapolis	Marion
Kelly, W. C.	Anderson	Madison	Kirshman, F. E.	Muncie	Delaware- Blackford
Kelly, W. R.	Goshen	Elkhart	Kirtley, J. M.	Crawfordsville	Montgomery
Kelly, Walter F.	Indianapolis	Marion	Kirtley, William R.	Indianapolis	Marion
Kelly, William M.	Indianapolis	Marion	Kiser, E. F.	Indianapolis	Marion
Kelsey, A. J.	Monterey	Pulaski	Kissinger, Charles C.	Indianapolis	Marion
Kelsey, L. E.	Kewanna	Fulton	Kissinger, K. L.	Angola	Steuben
Kelsey, Robert M.	La Porte	LaPorte	Kistler, James J.	LaPorte	LaPorte
Kemp, John T.	Michigan City	LaPorte	Kistner, Arthur W.	Elkhart	Elkhart
Kemp, M. Walter	Madison	Jefferson	Kistner, John W.	Elkhart	Elkhart
Kemp, W. A.	Connersville	Fayette- Franklin	Kitterman, Harry E.	Indianapolis	Marion
Kemper, A. T. (H)	Muncie	Delaware- Blackford	Klahr, Elsworth	South Bend	St. Joseph
			Klain, B. V.	Indianapolis	Marion
			Klamer, Charles H.	Jasper	Dubois
			Klaus, Julius M.	Crown Point	Lake
			Klein, H. P.	Fort Branch	Gibson
			Kleindorfer, R. L.	Evansville	Vanderburgh
			Kleinman, F. J.	Hebron	Porter
			Klepinger, H. E.	Lafayette	Tippecanoe

Name	City	County	Name	City	County
Kling, Victor E. F.	Michigan City	LaPorte	Lamb, E. B.	Indianapolis	Marion
Klingler, Maurice O.	Plymouth	Marshall	Lamb, Russell	Indianapolis	Marion
Kloess, Edward S.	Indianapolis	Marion	Lamber, C. K.	Indianapolis	Marion
Klotz, Joseph G.	Indianapolis	Marion	Lambert, C. W.	Los Angeles, Calif.	Marion
Knapp, A. B. (H)	Belleville, Ill.	Knox	Lamey, James L.	Anderson	Madison
Knapp, Arthur L.	South Bend	St. Joseph	Lamey, P. T.	Anderson	Madison
Kneidel, John H.	Indianapolis	Marion	Lancet, Robert O.	Terre Haute	Vigo
Knepple, L. R. (H)	Kokomo	Howard	Lane, W. H. (H)	Angola	Steuben
Knodel, Kenneth T.	South Bend	St. Joseph	Lane, Wm. H.	South Bend	St. Joseph
Knowles, Charles Y.	Indianapolis	Marion	Lang, Joseph E.	South Bend	St. Joseph
Knoy, Norris J.	Gary	Lake	Lang, Shirley C.	Evansville	Vanderburgh
Kobrak, H. F.	Gary	Lake	Langdon, H. K.	Indianapolis	Marion
Kobrin, M. W.	Gary	Lake	Langenbahn, C. J.	South Bend	St. Joseph
Koehler, Elmer G.	Elkhart	Elkhart	Langohr, John	Columbia City	Whitley
Kohlstaedt, George	Indianapolis	Marion	Langsdon, Fred	Gaston	Delaware-Blackford
Kohlstaedt, Karl C.	Indianapolis	Marion	Lansford, John	Redkey	Jay
Kohlstaedt, K. G.	Indianapolis	Marion	Laramore, Ward	Indianapolis	Marion
Kohne, G. J.	Decatur	Adams	Larkin, Bernard J.	Indianapolis	Marion
Kohrman, Benj. M.	Michigan City	LaPorte	Larmore, J. L.	Anderson	Madison
Kolanko, Leon A.	Hammond	Lake	Larmore, Sarah H.	Anderson	Madison
Kolettis, George J.	Gary	Lake	LaRocca, Joseph	Valparaiso	Porter
Komoroske, J. E.	East Chicago	Lake	Larrabee, James F.	Hammond	Lake
Koons, Karl M.	Indianapolis	Marion	Larrabee, W. H. (H)	New Palestine	Hancock
Koontz, William A.	Gas City	Grant	Larrison, G. D.	Morocco	Jasper-Newton
Kopcha, Joseph E.	Gary	Lake	Larson, G. O.	LaPorte	LaPorte
Kopp, Herschel S.	Indianapolis	Marion	Larson, John A.	Logansport	Cass
Kopp, O. A.	Anderson	Madison	LaSalle, R. M.	Wabash	Wabash
Koransky, David S.	Hammond	Lake	Lashley, Donald L.	Tell City	Perry
Korn, Jerome M.	Gary	Lake	Laubscher, Clarence	Evansville	Vanderburgh
Kornafel, L. H.	Indianapolis	Marion	Laudeman, W. A.	Elwood	Madison
Kraft, Bennett	Indianapolis	Marion	Lauer, D. B.	Dana	Parke-Vermillion
Kraft, Haldon C.	Noblesville	Hamilton	Lava, Irving M.	Michigan City	LaPorte
Kramer, A. A.	South Bend	St. Joseph	Lavengood, R. W.	Marion	Grant
Kraning, Kenneth	Kewanna	Fulton	Lawler, George F.	Indianapolis	Marion
Kratzer, E. F.	Kokomo	Howard	Lawrence, Joseph C.	Evansville	Vanderburgh
Kreible, Wm. W.	Terre Haute	Vigo	Laws, H. J.	Lafayette	Tippecanoe
Kress, George L.	Temple, Texas	Kosciusko	Laws, Kenneth F.	Lafayette	Tippecanoe
Kresler, Leon	Rensselaer	Jasper-Newton	Lawson, I. H.	Kendallville	Noble
Kretsch, Russell W.	Hammond	Lake	Layman, Daniel W. (H)	Indianapolis	Marion
Krieger, George M.	Michigan City	LaPorte	Leak, Robert H.	Lafayette	Tippecanoe
Kron, R. Vincent	Gary	Lake	Leasure, J. K.	Indianapolis	Marion
Krueger, Frederick W.	Richmond	Wayne-Union	Leasure, Kenneth	Etna Green	Kosciusko
Kruse, E. H.	Fort Wayne	Allen	Leatherman, C. A.	Muncie	Delaware-Blackford
Kruse, Walter E.	Fort Wayne	Allen	Leatherman, H. L.	Indianapolis	Marion
Kubik, Francis J.	Michigan City	LaPorte	Lebioda, Henry S.	Gary	Lake
Kubley, James D.	Plymouth	Marshall	Lee, A. H.	Terre Haute	Vigo
Kudele, L. T.	Whiting	Lake	Lee, Glen Ward	Richmond	Wayne-Union
Kuhn, Benjamin F.	Pierceton	Elkhart	Lee, John M.	Rushville	Rush
Kuehn, Carl C.	Indianapolis	Marion	Leff, Abe	Indianapolis	Marion
Kuhn, Frederick L.	South Bend	St. Joseph	Leffel, James M.	Indianapolis	Marion
Kuhn, Hedwig S.	Hammond	Lake	Lehman, Harold	Berne	Adams
Kuhn, Hugh A.	Hammond	Lake	Lehman, Kenneth M.	Topeka	LaGrange
Kuhn, R. W.	Wilkinson	Hancock	Lehman, Robert J.	Long Island, N. Y.	Marion
Kunkler, Joseph	Terre Haute	Vigo	Lehmberg, O. F.	Columbia City	Whitley
Kunkler, Wm. C.	Terre Haute	Vigo	Lehner, John J.	Fort Wayne	Allen
Kuntz, Herman W.	Indianapolis	Marion	Leich, Charles F.	Evansville	Vanderburgh
Kurtz, Fred B.	Indianapolis	Marion	Leininger, H. A. P.	Warsaw	Kosciusko
Kurtz, Philip L.	Indianapolis	Marion	Leiter, Arthur	Indianapolis	Whitley
Kurtz, William A.	Tipton	Tipton	Lemon, Herbert K.	Goshen	Elkhart
Kwitny, I. J.	Indianapolis	Marion	Lenk, George G.	Fort Wayne	Allen
L			Leonard, Henry S.	Indianapolis	Marion
LaBier, C. Russell	Terre Haute	Vigo	Leser, R. U.	Indianapolis	Marion
LaBier, Clarence R. (H)	Terre Haute	Vigo	Leslie, Ermil	Evansville	Vanderburgh
LaDine, C. B.	Indianapolis	Marion	Lett, Emory B.	Loogootee	Daviess-Martin
Ladig, Donald S.	Fort Wayne	Allen	Levering, Guy P.	Lafayette	Tippecanoe
LaDuron, Jules F.	Muncie	Delaware-Blackford	Levi, Leon	Indianapolis	Marion
LaFollette, Forrest R.	Whiting	Lake	Levin, Eli	East Chicago	Lake
LaFollette, Robert E.	New Albany	Floyd			
Laird, L. A.	Richmond	Wayne-Union			

Name	City	County	Name	City	County
Levin, Ralph T.	Indianapolis	Marion	Lybrook, D. E.	Young America	Cass
Lewis, J. R.	Indianapolis	Marion	Lybrook, William B.	Indianapolis	Marion
Lewis, James F.	Liberty	Wayne-Union	Lynch, Harold D.	Evansville	Vanderburgh
Lewis, Robert J.	Lawrence	Marion	Lynch, Otho R.	Lafayette	Tippecanoe
Libbert, E. L.	Indianapolis	Marion	Lynch, Otis R.	Marengo	Vanderburgh
Libnoch, Casimir	Chicago, Ill.	St. Joseph	Lynch, Paul	Evansville	Crawford
Lichtenberg, Melvin	Indianapolis	Marion	Lynn, F. M. (H)	Peru	Miami
Lidikay, Edward C.	Indianapolis	Marion	Lyon, Florence	Portland	Jay
Life, Homer	New Castle	Henry	Lyons, R. E., Jr.	Bloomington	Owen-Monroe
Lindenborg, Paul G.	Indianapolis	Marion			
Lindsay, H. B.	Washington	Daviess-Martin		M	
Line, H. E.	Chili	Miami	MacDonald, J. A.	Indianapolis	Marion
Ling, John F.	Indianapolis	Marion	Macer, Clarence G.	Evansville	Vanderburgh
Lingeman, Byron N.	Crawfordsville	Montgomery	Machledt, J. H.	Whiteland	Johnson
Lingeman, E. L.	Indianapolis	Marion	MacKenzie, Pierce	Evansville	Vanderburgh
Lingeman, Raleigh E.	Indianapolis	Marion	Mackey, Harry S.	Indianapolis	Marion
Link, Goethe	Indianapolis	Indianapolis	Mackey, John E.	Indianapolis	Spencer
Linn, E. E.	LaPorte	LaPorte	Macy, George W.	Columbus	Bartholomew-Brown
Linton, C. D.	Walkerton	St. Joseph	Mader, John H.	Richmond	Wayne-Union
Linton, C. E.	Medaryville	Pulaski	Magennis, H. L.	Indianapolis	Marion
Lionberger, John R.	South Bend	St. Joseph	Mahoney, Charles L.	Terre Haute	Vigo
Lippoldt, Charles L.	Batesville	Ripley	Mahuron, Boyd L.	Greensburg	Decatur
Liss, Emanuel C.	South Bend	St. Joseph	Majsterek, S. L.	Gary	Lake
List, Harold E.	Key West	Grant	Makovsky, Theodore	Valparaiso	Porter
	Florida		Malcolm, Russell	Richmond	Wayne-Union
Littell, J. J.	Indianapolis	Marion	Malmstone, F. A.	Griffith	Lake
Little, John W. (H)	Indianapolis	Marion	Malone, L. A.	Terre Haute	Vigo
Little, Wm. J.	Bicknell	Knox	Malott, Fred	Converse	Miami
Litzenberger, S. W.	Anderson	Madison	Malouf, S. D.	Peru	Miami
Lloyd, Robert P.	Ft. Wayne	Allen	Maly, C. H.	Indianapolis	Marion
Lochry, R. L.	Indianapolis	Marion	Manifold, Harold M.	Muncie	Delaware-Blackford
Lockhart, Jack M.	Connersville	Fayette-Franklin	Manion, Marlow W.	Indianapolis	Marion
Loehr, W. M.	Indianapolis	Marion	Manley, C. N.	Rising Sun	Dearborn-Ohio
Loewenstein, W. L.	Terre Haute	Vigo	Mann, Mortimer	Indianapolis	Marion
Logan, A. R.	Petersburg	Pike	Manning, Joseph C.	Indianapolis	Marion
Logan, F. W.	Mishawaka	St. Joseph	Manning, K. R.	Indianapolis	Marion
Logan, James Z.	Richmond	Wayne-Union	Manzie, Michael	Lyons	Green
Logan, Jesse R.	Evansville	Vanderburgh	Maple, J. B.	Sullivan	Sullivan
Lohman, Robert M.	Fort Wayne	Allen	Marchand, Austin F.	Haubstadt	Gibson
Lomax, Claude C.	Indianapolis	Marion	Marchand, Edwin V.	Haubstadt	Gibson
Long, Max	Marion	Grant	Marchant, Clarence H.	Bloomington	Owen-Monroe
Long, Paul L.	Anderson	Madison	Marcus, Emmanuel	Hammond	Lake
Long, W. H.	Indianapolis	Marion	Marcus, M. C.	Gary	Lake
Loomis, N. S.	Indianapolis	Marion	Maris, Lee J.	Attica	Fountain-Warren
Loop, Floyd A.	Lafayette	Tippecanoe	Markel, I. J.	Elkhart	Elkhart
Loop, Frederick A.	Lafayette	Tippecanoe	Markle, Joseph G.	Hobart	Lake
Lord, G. C.	Indianapolis	Marion	Marks, H. H.	Huntington	Huntington
Lorenty, T. B.	Gary	Lake	Marks, Ora L.	East Chicago	Lake
Loring, Mark L.	Valparaiso	Porter	Marks, Salvo D.	Hammond	Lake
Loudermilk, J. L.	Ft. Wayne	Allen	Marr, Griffith	Columbus	Bartholomew-Brown
Love, George N.	Indianapolis	Marion	Marsh, Chester A.	Hagerstown	Henry
Love, John R.	Terre Haute	Vigo	Marsh, George W.	Lafayette	Tippecanoe
Lovell, Martin H.	Gary	Lake	Marshall, A. L.	Indianapolis	Marion
Lovett, H. D.	Whitestown	Boone	Marshall, Albert L., Jr.	Indianapolis	Marion
Loving, J. B.	New Goshen	Vigo	Marshall, C. R.	Indianapolis	Marion
Luckett, Coen L.	Terre Haute	Vigo	Marshall, George	Bourbon	Marshall
Luckey, H. A.	Wolk Lake	Noble	Marshall, L. C.	Mount Summit	Henry
Luckey, R. C.	Wolf Lake	Noble	Marshall, Millard R.	Whiting	Lake
Ludwick, Harry	South Bend	St. Joseph	Martin, C. E.	Lynn	Randolph
Ludwig, Oscar D.	Indianapolis	Marion	Martin, Charles F.	Indianapolis	Marion
Lukemeyer, L. C. (H)	Huntingburg	Dubois	Martin, Frank D.	Bedford	Lawrence
Lukemeyer, St. John	Jasper	Dubois	Martin, Floyd S.	Goshen	Elkhart
Lukenbill, Emery D.	Indianapolis	Marion	Martin, Guy	Seymour	Jackson
Lundberg, Ralph A.	Indianapolis	Marion	Martin, Harold R.	Lafayette	Tippecanoe
Lundt, Milo O.	Elkhart	Elkhart	Martin, Hugh E.	Indianapolis	Marion
Lung, B. D.	Kokomo	Howard			
Lutes, D. L.	Edinburg	Johnson			
Luthy, Karl R.	South Bend	St. Joseph			
Lutz, Georgianna	Gary	Lake			
Luzadder, J. E. (H)	Bloomington	Owen-Monroe			
Luzadder, J. E., Jr.	New Carlisle	St. Joseph			

Name	City	County	Name	City	County
Martin, H. G.	Lafayette	Tippecanoe	McDaniel, F. P.	Atlanta	Hamilton
Martin, Joe M.	Lafayette	Tippecanoe	McDevitt, D. R.	Indianapolis	Marion
Martin, L. H.	Indianapolis	Marion	McDonald, J. D.	Evansville	Vanderburgh
Martin, W. B.	LaPorte	LaPorte	McDonald, R. M.	South Bend	St. Joseph
Martin, Will J.	Kokomo	Howard	McDonald, V. G.	Anderson	Madison
Martineau, Perry C.	Ft. Wayne	Allen	McDowell, George A.	Ft. Wayne	Allen
Martz, Bill L.	Indianapolis	Marion	McDowell, M. M.	Vincennes	Knox
Martz, Carl D.	Indianapolis	Marion	McEachern, Cecil	Ft. Wayne	Allen
Maschmeyer, R. H.	Shoals	Daviess- Martin	McElroy, J. S.	New Castle	Henry
			McElroy, R. S.	Princeton	Gibson
			McEwen, J. W.	Terre Haute	Vigo
Mason, Bernard	South Bend	St. Joseph	McFadden, James M.	Lafayette	Tippecanoe
Mason, Donald G.	Angola	Steuben	McFarland, Corley B.	South Bend	St. Joseph
Mason, Everett E.	Evansville	Vanderburgh	McGrath, Michael F.	Indianapolis	Marion
Mason, Lester M.	Terre Haute	Vigo	McGuff, Paul	Indianapolis	Delaware- Blackford
Mason, L. R.	Muncie	Delaware- Blackford			
Masters, John B.	Indianapolis	Marion	McGuire, D. F.	East Chicago	Lake
Masters, J. M.	Indianapolis	Marion	McIlwain, Eleanor	Marion	Grant
Masters, R. J.	Indianapolis	Marion	McIlwain, Robert	Marion	Grant
Mather, J. W.	East Gary	Lake	McIndoo, R. E.	Kokomo	Howard
Mather, Robert	Brookston	Tippecanoe	McIntosh, Wilbert (H)	Riley	Vigo
Mathews, W. C.	Kentland	Jasper- Newton	McIntyre, Charles J.	Indianapolis	Marion
			McIntyre, J. M.	Indianapolis	Marion
			McKee, C. E. (H)	Dublin	Wayne- Union
Mathys, Alfred	Mauckport	Harrison			
Matthew, John R.	North Judson	Starke	McKee, Horace N.	Elkhart	Elkhart
Matthew, W. B.	Indianapolis	Marion	McKee, H. S.	Greensburg	Decatur
Matthews, B. J.	Indianapolis	Marion	McKeeman, D. H.	Ft. Wayne	Allen
Matthews, Chas. B.	Hammond	Lake	McKeeman, L. S.	Ft. Wayne	Allen
Matthews, D. W.	North Vernon	Jennings	McKenna, H. J.	South Bend	St. Joseph
Matthews, William M.	Indianapolis	Marion	McKinley, A. D.	Indianapolis	Marion
Mattox, Don M.	Terre Haute	Vigo	McKinley, Joseph	Indianapolis	Tippecanoe
Maurer, J. F.	Brazil	Clay	McKinney, D. H.	Lafayette	Tippecanoe
Maurer, Robert M.	Brazil	Clay	McKittrick, Jack	Washington	Daviess- Martin
Maxon, Roy V.	Lapel	Madison			
Maxwell, J. B. (H)	Logansport	Cass	McKittrick, Wm. O.	Washington	Daviess- Martin
May, George A.	Madison	Jefferson			
May, R. M.	Gary	Lake	McLaughlin, C. P.	Pendleton	Madison
Mayfield, C. H.	Reynolds	Tippecanoe	McLaughlin, G. C.	Terre Haute	Vigo
McAdams, Hugh B.	Lafayette	Tippecanoe	McLaughlin, James R.	Flora	Carroll
McArdle, Edward G.	Ft. Wayne	Allen	McMahan, Virgil	Vincennes	Knox
McBride, James S.	Indianapolis	Marion	McMeel, J. E.	South Bend	St. Joseph
McBride, Noel S.	Terre Haute	Vigo	McMichael, F. J.	Gary	Lake
McCabe, J. E.	Otterbein	Benton	McMichael, R. M.	Muncie	Delaware- Blackford
McCabe, Theodore E.	Ft. Wayne	Allen			
McCallum, Joseph T. C.	Indianapolis	Marion	McMillan, F. G.	Indianapolis	Marion
McCarthy, Daniel J.	Indianapolis	Marion	McNabb, G. B.	Carthage	Rush
McCarthy, F. G.	Terre Haute	Vigo	McNairy, Donald J.	Ft. Wayne	Allen
McCarthy, Jeremiah A.	Whiting	Lake	McNamara, John P.	Indianapolis	Marion
McCartney, Donald H.	Indianapolis	Marion	McNaughton, L. M.	Washington	Daviess- Martin
McCarty, Virgil	Princeton	Gibson			
McCaskey, C. H.	Indianapolis	Marion	McNeely, M. J.	Dillsboro	Dearborn- Ohio
McCaskey, G. H.	Winamac	Pulaski			
McClain, Marvin	Scottsburg	Scott	McQuiston, R. J.	Indianapolis	Marion
McClellan, John B.	Goodland	Jasper- Newton	McTurnan, Robert W.	Indianapolis	Marion
			McVaugh, Charles C.	Pendleton	Madison
			McVey, C. A.	Hammond	Lake
McClelland, D. C.	Lafayette	Tippecanoe	McWilliams, W. B.	Liberty	Wayne- Union
McClintock, James A.	Louisville, Ky.	Delaware- Blackford			
McClure, S. E.	Monon	Tippecanoe	Mead, C. H.	Bluffton	Wells
McConnell, Wm. C.	Sunman	Ripley	Meade, W. W.	Bicknell	Knox
McCool, J. H.	Evansville	Vanderburgh	Medcalf, N. L.	Larmer	Spencer
McCool, W. E. (H)	Evansville	Vanderburgh	Meek, Loring (H)	Rochester	Fulton
McCord, C. B.	Veedersburg	Fountain- Warren	Megenhardt, D. S.	Indianapolis	Marion
			Mehl, Rudolph A.	Evansville	Vanderburgh
			Meihaus, John E.	Los Angeles, Calif.	Marion
McCormick, C. O., Jr.	Indianapolis	Marion			
McCormick, C. O., Sr.	Indianapolis	Marion	Meikle, Louise J.	W. Lafayette	Tippecanoe
McCormick, H. D.	Vincennes	Knox	Meiks, Lyman T.	Indianapolis	Marion
McCormick, W. C.	Terre Haute	Vigo	Meiner, J. A.	Kokomo	Howard
McCown, P. E.	Indianapolis	Marion	Meiser, Robert	Huntington	Huntington
McCoy, Roy R.	Ft. Wayne	Allen	Meister, Doris	Anderson	Madison
McCracken, J. O.	Montgomery	Daviess- Martin	Melloh, A. F.	Indianapolis	Marion
			Mendenhall, C. D.	Indianapolis	Marion
McCraley, William J.	South Bend	St. Joseph	Mendenhall, Edgar	Ft. Wayne	Allen
McCullough, J. Y.	New Albany	Floyd	Mendenhall, W. E.	Indianapolis	Marion
McDonald, Frank C.	New Castle	Henry	Mentendiek, M. H.	Indianapolis	Marion

Name	City	County	Name	City	County
Mendez, Carlos	Elkhart	Elkhart	Minczewski, Richard C.	Gary	Lake
Mercer, Herman	Jeffersonville	Clark	Mininger, Edward P.	Elkhart	Elkhart
Mercer, Samuel R.	Ft. Wayne	Allen	Mino, Victor H.	Evansville	Vanderburgh
Merchant, Raymond	Crown Point	Jasper-Newton	Mirro, John A.	Lowell	Lake
Meredith, E. J.	Richmond	Wayne-Union	Mishkin, Irving	Elkhart	Elkhart
Mericle, Earl	Indianapolis	Marion	Mitchell, Albert M.	Terre Haute	Vigo
Merrell, B. M.	Rockville	Parke-Vermillion	Mitchell, E. T.	Romney	Tippecanoe
Merrell, Paul	Indianapolis	Marion	Mitchell, Earl H.	Indianapolis	Marion
Mertz, H. O.	Indianapolis	Marion	Mitchell, G. L.	Smithville	Monroe
Mervis, Frank H.	East Chicago	Lake	Mitchell, J. I.	Salem	Washington
Messer, F. W.	Kendallville	Noble	Mitchell, R. E.	Ft. Stanton, New Mexico	Marion
Metcalfe, George B.	Anderson	Madison	Mitman, F. B.	Huntington	Huntington
Metcalfe, G. E.	South Bend	St. Joseph	Moats, C. F.	Ft. Wayne	Allen
Mettler, Don C.	Ligonier	Noble	Moats, G. E.	Ft. Wayne	Allen
Meyer, Herman A.	Ft. Wayne	Allen	Modisett, Jackson W.	Madison	Jefferson
Meyer, K. T.	Evansville	Vanderburgh	Modisett, Marcella S.	Madison	Jefferson
Meyer, Milo G.	Michigan City	LaPorte	Modjeski, Joseph R.	Hammond	Lake
Meyer, Orlando L.	Bedford	Lawrence	Modjeski, Raymond J.	Hammond	Lake
Meyer, R. C.	Vincennes	Knox	Moehlenkamp, C. E.	Evansville	Vanderburgh
Meyer, Theodore O.	Ft. Wayne	Allen	Moening, W. P.	Indianapolis	Marion
Meyn, Werner P.	Terre Haute	Vigo	Mohler, Floyd W.	Indianapolis	Marion
Michael, Amos C.	Indianapolis	Marion	Mohr, Ann L. M.	W. Terre Haute	Vigo
Michael, Isaac E.	Frankfort	Clinton	Molengraft, C. J.	Gary	Lake
Michaelis, S. C.	Ft. Wayne	Allen	Molloy, W. J. (H)	Muncie	Delaware-Blackford
Michaels, J. F.	Edinburg	Johnson	Molt, W. F.	Indianapolis	Marion
Micheli, A. J.	Indianapolis	Marion	Monroe, F. Bruce	Crown Point	Lake
Middleton, H. N.	Indianapolis	Marion	Montgomery, J. R.	Owensville	Gibson
Middelton, Thomas O.	Pittsburgh, Pa.	Lawrence	Montgomery, L. G.	Muncie	Delaware-Blackford
Mikesch, W. H.	South Bend	St. Joseph	Montgomery, S. B.	Cynthiana	Posey
Miklozek, John E.	Terre Haute	Vigo	Montgomery, Wm. F.	Indianapolis	Marion
Miley, Weir M.	Anderson	Madison	Moore, B. B.	Indianapolis	Marion
Miller, Albert W.	Indianapolis	Marion	Moore, Edwin G.	Gary	Lake
Miller, Carl G.	Ft. Wayne	Allen	Moore, H. T.	Indianapolis	Marion
Miller, Charles A. (H)	Princeton	Gibson	Moore, Martha	Madison	Jefferson
Miller, D. B.	Terre Haute	Vigo	Moore, R. G.	Vincennes	Knox
Miller, E. H.	Valparaiso	Porter	Moore, Robert M.	Indianapolis	Marion
Miller, Earl Robert	Indianapolis	Marion	Moore, Thomas C.	Muncie	Delaware-Blackford
Miller, H. Allison	Marion	Grant	Moore, W. C.	Muncie	Delaware-Blackford
Miller, H. L.	West Baden	Orange	Moosey, Louis	Union Mills	LaPorte
Miller, Harold E.	Seymour	Jackson	Moran, Mark M.	Portland	Jay
Miller, H. Paul	Ft. Wayne	Allen	Moran, Noel D.	Versailles	Ripley
Miller, Hugh A., Jr.	Elkhart	Elkhart	Moravec, Arthur E.	Ft. Wayne	Allen
Miller, Iva M. T.	Richmond	Marion	Morgan, Isabel	Charleston, W. Va.	Hendricks
Miller, Jack B.	Cleveland, Ohio	Pike	Morgan, S. P.	LaPorte	LaPorte
Miller, J. Don	Indianapolis	Marion	Moriarty, John R.	Indianapolis	Marion
Miller, James C.	Greensburg	Decatur	Morr, J. W. (H)	Albion	Noble
Miller, John R.	Indianapolis	Marion	Morrison, Russell J.	Logansport	Cass
Miller, L. B.	Evansville	Vanderburgh	Morris, Hyman	Gary	Lake
Miller, L. R.	Winslow	Pike	Morris, J. W.	Indianapolis	Delaware-Blackford
Miller, M. E.	Goshen	Elkhart	Morris, Robert A.	Anderson	Madison
Miller, Mahlon F.	Ft. Wayne	Allen	Morris, W. F.	Princeton	Gibson
Miller, Milton	Evansville	Vanderburgh	Morris, Warren V.	Monticello	Tippecanoe
Miller, Milo	South Bend	St. Joseph	Morrison, C. C.	Greensburg	Decatur
Miller, Minor	Evansville	Vanderburgh	Morrison, D. A.	Kokomo	Howard
Miller, Orval J.	Ft. Wayne	Allen	Morrison, G. G.	Portland	Jay
Miller, R. S.	Indianapolis	Marion	Morrison, John S. (H)	Lafayette	Tippecanoe
Miller, Ray D.	Indianapolis	Marion	Morrison, J. T.	Greensburg	Decatur
Miller, Richard C.	Shelbyville	Shelby	Morrison, Lindsey (H)	Hammond	Lake
Miller, Richard H.	Ft. Wayne	Allen	Morrison, Lewis E. II	Indianapolis	Marion
Miller, Robert J.	Evansville	Vanderburgh	Morrison, W. R.	Kokomo	Howard
Miller, Roland E.	Lafayette	Tippecanoe	Morrow, R. D.	Connersville	Fayette-Franklin
Miller, S. J.	W. Lafayette	Tippecanoe	Mortenson, L. J.	Ft. Wayne	Allen
Miller, S. T.	Elkhart	Elkhart	Morton, Walter P.	Indianapolis	Marion
Miller, Virgil	Akron	Fulton	Moser, E. B.	Windfall	Tipton
Miller, Wm. A.	Hagerstown	Henry	Moser, Edward	Woodburn	Allen
Miller, Wm. E.	South Bend	St. Joseph	Moser, R. H.	Indianapolis	Marion
Miller, Wm. J.	Ft. Wayne	Allen	Moses, George E.	Worthington	Greene
Miller, Wm. T.	Indianapolis	Marion	Moses, Robert E.	Worthington	Greene
Millikan, William	Indianapolis	Marion			
Mills, Fred E.	Evansville	Vanderburgh			
Mills, J. F.	Wabash	Wabash			

Name	City	County
Moss, Harlan B.	Indianapolis	Lake
Moss, M. J.	Yorktown	Delaware-Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, M. H.	Indianapolis	Marion
Mott, C. A.	South Bend	St. Joseph
Moulton, Lillian	Indianapolis	Marion
Mount, M. S.	Bloomfield	Greene
Mount, Wm.	Crawfordsville	Montgomery
Mountain, Francis	Connersville	Fayette-Franklin
Moutoux, J. E.	Indianapolis	Marion
Mozingo, A. E.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Lawrence W.	Ft. Wayne	Allen
Mueller, Lillian B.	Indianapolis	Marion
Muhleman, C. E.	LaPorte	LaPorte
Mull, P. L. (H)	Louisville, Ky.	Washington
Muller, Lullus P.	Boswell	Benton
Muller, Paul F.	Indianapolis	Marion
Mullikin, C. W.	Greensburg	Decatur
Mullin, H. Y.	Rockfield	Carroll
Mumford, E. B.	Indianapolis	Marion
Muncie, H. L.	Brazil	Clay
Munk, C. E.	Kendallville	Noble
Murdock, H. L.	Ft. Wayne	Allen
Murphy, E. C.	South Bend	St. Joseph
Murphy, E. W.	New Albany	Harrison
Murphy, George M.	Franklin	Johnson
Murphy, Harry	Franklin	Johnson
Murphy, Josephine	South Bend	St. Joseph
Murphy, M. G.	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, F. N.	Kokomo	Howard
Musacchio, Frederick A.	Hammond	Lake
Musselman, G. G.	Terre Haute	Vigo
Myers, B. D. (H)	Bloomington	Owen-Monroe
Myers, Charles W.	Indianapolis	Marion
Myers, Harold Allen	Indianapolis	Marion
Myers, R. V.	Indianapolis	Marion
Myers, Wm. C.	Dana	Parke-Vermillion

N

Nafe, C. A.	Indianapolis	Marion
Nahrwold, Elmer W.	Ft. Wayne	Allen
Nakadate, Katsumi J.	East Chicago	Lake
Nance, W. K.	Vincennes	Knox
Napper, Floyd	Scottsburg	Scott
Nash, Charles B.	Valparaso	Porter
Nash, Justin R.	Albion	Noble
Nason, R. A.	Garrett	DeKalb
Naugle, R. A.	Wabash	Wabash
Nave, H. E.	Fountaintown	Shelby
Navin, Hugh K.	Fortville	Hancock
Nay, E. O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Lake
Need, Louis T.	Indianapolis	Marion
Neely, A. S.	Indianapolis	Marion
Nehil, L. W.	Indianapolis	Marion
Neidballa, E. G.	Bristol	Elkhart
Neier, O. C. (H)	Indianapolis	Marion
Neifert, Noel	Tell City	Perry
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Paul Leon	Anderson	Madison
Nelson, R. B.	Hammond	Lake
Nelson, Raymond	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (H)	Evansville	Vanderburgh

Name	City	County
Nesbit, L. L.	Anderson	Madison
Nesbit, O. B. (H)	Gary	Lake
Netherton, C. R.	Chalmers	Tippecanoe
Neucks, Howard C.	Evansville	Vanderburgh
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, K. O.	Lafayette	Tippecanoe
Neuwalt, Frank	Gary	Lake
Newby, A. C.	Sheridan	Hamilton
Newby, Eugene	Sheridan	Hamilton
Newcomb, Wm. K.	Royal Center	Cass
Newland, A. E.	Bedford	Lawrence
Newman, A. E.	Evansville	Vanderburgh
Niblack, E. S. (H)	Manhasset, N. Y.	Vigo
Niblack, J. S.	East Chicago	Lake
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Wm. E. (H)	Hammond	Lake
Nickel, Allen C.	Bluffton	Wells
Nicosia, J. B.	East Chicago	Lake
Nie, Grover	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermeyer, Alfred	Evansville	Vanderburgh
Nigh, R. M.	Fairland	Shelby
Nil, John H.	Ft. Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Nixon, J. E.	Portland	Jay
Noble, T. B., Sr. (H)	Indianapolis	Marion
Noble, T. B., Jr.	Indianapolis	Marion
Nodinger, Louis	Hammond	Lake
Nolan, Robert E.	English	Orange
Nolt, E. V.	Columbia City	Whitley
Nolting, H. F.	Indianapolis	Marion
Nonte, Leo R.	Indianapolis	Marion
Norman, O. B.	Indianapolis	Marion
Norman, Wm. H.	Indianapolis	Marion
Norris, Allen A.	Elkhart	Elkhart
Norris, Ernest B.	Middlebury	Elkhart
Norris, H. L.	Indianapolis	Marion
Norris, Mary A.	Indianapolis	Marion
Norton, H. J.	Columbus	Bartholomew-Brown
Norton, Horace	Crane	Daviess-Martin
Norwick, Sydney	San Lorenzo, Calif.	Marion
Nourse, Myron H.	Indianapolis	Marion
Nugen, Harold	Auburn	DeKalb
Nugent, Edwin S.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush

O

Oak, David	Hanna	LaPorte
Oak, D. D.	La Crosse	LaPorte
Obery, George	Batesville	Ripley
Ochsner, Harold C.	Indianapolis	Marion
Ockerman, Kenneth R.	Demotte	Jasper-Newton
O'Connor, James J.	East Chicago	Lake
O'Dell, Harry C.	Farmersburg	Sullivan
O'Dell, Harry W.	Philadelphia, Pa.	Sullivan
O'Dell, Thomas A.	Indianapolis	Marion
Olcott, C. W.	Aurora	Dearborn-Ohio
O'Leary, F. T.	Logansport	Cass
Oliphant, F. W.	Mount Vernon	Posey
Oliphant, J. T.	Farmersburg	Sullivan
Oliphant, R. W.	Terre Haute	Vigo
Olney, Thomas A. (H)	South Bend	St. Joseph
Olson, K. L.	South Bend	St. Joseph
Olvey, Ottis N.	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Andrews	Huntington

Name	City	County	Name	City	County
O'Neil, Martin J.	Rensselaer	Jasper-Newton	Payne, A. C.	East Chicago	Lake
Openshaw, J. F.	Goodland	Jasper-Newton	Paynter, L. W. (H)	Salem	Washington
Oppenheimer, Ernst	Evansville	Vanderburgh	Paynter, Morris B.	Southport	Marion
Orders, C. E.	Indianapolis	Marion	Peacock, Norman F.	Crawfordsville	Montgomery
O'Rourke, Carroll	Ft. Wayne	Allen	Peacock, Robert	Indianapolis	Marion
Ornelas, Joseph P.	Gary	Lake	Pearce, Roy V.	Terre Haute	Vigo
Orr, Robert	Mishawaka	St. Joseph	Pearlman, Samuel	Lafayette	Tippecanoe
Osborne, Harry S.	Roachdale	Marion	Pearson, John R.	Bedford	Lawrence
Oster, Ellis	Portland, Ore.	Delaware-Blackford	Pearson, Lyman R.	Indianapolis	Marion
Osterman, Louis	Seymour	Jackson	Pearson, Wm. E.	Wabash	Wabash
Ostrowski, R. O.	Hammond	Lake	Pebworth, A. C.	Indianapolis	Marion
Oswalt, James T.	Mitchell	Lawrence	Pebworth, J. T.	Tyrone, New Mexico	Marion
Otten, Claude F.	Indianapolis	Marion	Peck, Edward A.	Hammond	Lake
Otten, Ralph E.	Darlington	Montgomery	Peck, Franklin B.	Indianapolis	Marion
Ottinger, R. C.	Indianapolis	Marion	Peck, James F.	Princeton	Gibson
Overman, F. V.	Tipton	Tipton	Peirce, James D.	Indianapolis	Marion
Overpeck, Charles	Greensburg	Decatur	Pence, Benjamin F.	Columbia City	Whitley
Overpeck, George H.	Alexandria	Madison	Pennington, Phillip E.	Indianapolis	Marion
Overshiner, Lyman	Columbus	Bartholomew-Brown	Pennington, W. E.	Indianapolis	Marion
Owen, Abraham	Bloomington	Owen-Monroe	Pentecost, Paul S.	Richmond	Wayne-Union
Owen, J. E.	Indianapolis	Marion	Permer, Erwin	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe	Perrin, K. F.	Ft. Wayne	Allen
Owens, Richard R.	Muncie	Delaware-Blackford	Perry, F. G.	Ft. Wayne	Allen
Owens, Thomas R.	Muncie	Delaware-Blackford	Peters, R. J. D.	Indianapolis	Marion
Owens, Tracy	Indianapolis	Marion	Peterson, Joel A.	Lafayette	Tippecanoe
Owens, Walter Lee	Manhattan, Kan.	Orange	Petitjean, H. G.	Haubstadt	Gibson
Owsley, Charlotte	Hartford City	Delaware-Blackford	Petranoff, T. V.	Indianapolis	Marion
Owsley, Guy A.	Hartford City	Delaware-Blackford	Petrass, Andrew	South Bend	St. Joseph
Oyer, J. H.	Ft. Wayne	Allen	Petronella, S. J.	East Chicago	Lake
P			Pettibone, C. R.	East Lansing, Mich.	Lake
Pace, J. V.	New Albany	Floyd	Pettijohn, F. L. (H)	Indianapolis	Marion
Padgett, E. E.	Indianapolis	Marion	Petway, Allen P.	Madison	Jefferson
Paff, W. A.	Elkhart	Elkhart	Peyton, Frank W.	Lafayette	Tippecanoe
Pahmeier, J. W.	Sandborn	Knox	Pfaff, Dudley	Indianapolis	Marion
Paine, George E.	Elkhart	Elkhart	Pfaff, John A. (H)	Indianapolis	Marion
Painter, L. W.	Winchester	Randolph	Pfaffin, C. A. (H)	Indianapolis	Marion
Palm, John M.	Brazil	Clay	Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Palmer, Russell H.	Gary	Lake	Phares, Robert W.	Kokomo	Howard
Panares, Solomon V.	Hammond	Lake	Phipps, D. L. (H)	Union City	Johnson
Pancost, Ruth Hoetzer	Elkhart	Elkhart	Phipps, Leland K.	Union City	Randolph
Pancost, Vernon K.	Elkhart	Elkhart	Piazza, Leonard F.	Michigan City	LaPorte
Pandolfo, Harry	Indianapolis	Marion	Pickett, Robert D.	Indianapolis	Marion
Paris, D. W.	Kokomo	Howard	Pierce, Gene Stratton	Wheatland	Knox
Paris, J. M.	New Albany	Floyd	Pierce, H. J.	Terre Haute	Vigo
Parke, D. Davis	South Bend	St. Joseph	Pierson, P. R.	New Albany	Floyd
Parker, Carl B.	Wingate	Montgomery	Pierson, Robert H.	Crawfordsville	Montgomery
Parker, C. B.	Ft. Wayne	Allen	Pierson, Thomas A.	New Palestine	Hancock
Parker, E. E.	Oxford	Benton	Pike, Warren H.	Hobart	Lake
Parker, G. F.	Greencastle	Putnam	Pilcher, Jack	Indianapolis	Marion
Parker, H. C.	Gary	Lake	Pilot, Jean	Hammond	Lake
Parker, J. F.	Indianapolis	Marion	Pippenger, W. G.	Brook	Jasper-Newton
Parker, John T.	Gary	Lake	Pirkle, H. B.	Rockville	Parke-Vermillion
Parker, Portia	Indianapolis	Marion	Pitkin, Edward M.	Martinsville	Morgan
Parks, George	Hartford City	Delaware-Blackford	Pitkin, M. C.	Martinsville	Morgan
Parratt, Louis W.	Gary	Lake	Plain, George	South Bend	St. Joseph
Parrish, Richard K.	Decatur	Adams	Plank, C. Robert	Michigan City	LaPorte
Patrick, G. B.	Elkhart	Elkhart	Ploughe, Monroe L. (H)	Elwood	Madison
Patten, V. C. (H)	Morristown	Shelby	Ploughe, R. R.	Elwood	Madison
Patterson, Wm. K.	Anderson	Madison	Polhemus, Gretchen I.	New Albany	Floyd
Patton, Martin T.	Indianapolis	Marion	Polhemus, Warren C.	Anderson	Madison
Paul, Wm. Thomas F.	Hammond	Lake	Pollak, Lewis	Indianapolis	Marion
Paulissen, George T.	Beech Grove	Marion	Pollard, Walter	Evansville	Vanderburgh
Pauszek, Thomas B.	South Bend	St. Joseph	Pollom, Robert R.	Crawfordsville	Montgomery
			Pomeroy, Rex K.	Plymouth	Marshall
			Popp, M. F.	Ft. Wayne	Allen
			Porter, Carl M.	Jasonville	Greene
			Porter, E. A.	Westport	Decatur
			Porter, George C.	Linton	Greene
			Porter, Jack	Lebanon	Boone

Name	City	County
Porter, John R.	Lebanon	Boone
Porter, M. F.	Ft. Wayne	Allen
Portteus, Walter L.	Franklin	Johnson
Possolt, T. R.	Plymouth	Marshall
Poston, C. L.	Memphis, Tenn.	Wayne- Union
Powell, E. H.	Valparaiso	Porter
Powell, J. Paxton	Marion	Grant
Powell, Nettie B. (H)	Marion	Grant
Premuda, F. E.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson
Prentiss, Nelson H.	Ft. Wayne	Allen
Present, Julian	Evansville	Vanderburgh
Price, Douglas W.	Nappanee	Elkhart
Price, Ernest H.	Danville	Hendricks
Price, James O.	Indianapolis	Marion
Price, Melvin D.	Nappanee	Elkhart
Price, W. A. (H)	Nappanee	Elkhart
Prosser, Wm. O. H.	Bloomington	Owen- Monroe
Proudfit, Charles H.	South Bend	St. Joseph
Province, O. A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, S. Edward	Dunkirk	Delaware- Blackford
Pryor, R. C.	Indianapolis	Marion
Przednowek, A. C.	LaPorte	LaPorte
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, B. H.	Wolcottville	Noble
Purcell, Jack H.	Winslow	Pike
Puryear, J. O.	Gary	Lake
Puterbaugh, K. E.	Albany	Delaware- Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Quick, Wm. J.	Muncie	Delaware Blackford
Quickel, Daniel S. (H)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion

R

Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rabson, Salem M.	Ft. Wayne	Allen
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Bloomington	Lake
Ragsdale, H. C.	Bedford	Lawrence
Rainey, E. A.	Lebanon	Boone
Ramage, W. F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	East Chicago	Lake
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, H. S.	Bloomington	Owen- Monroe
Ranes, J. R.	Mt. Vernon	Posey
Raney, B. B.	Linton	Greene
Rang, A. A.	Washington	Daviess- Martin
Rang, Robert H.	Washington	Daviess- Martin
Ranke, John W. H. (H)	Washington	Allen
Raper, George T.	Freelandville	Knox
Raphael, Isidor J.	Evansville	Vanderburgh
Rarick, Alden J.	Terre Haute	Vigo
Rariden, L. B.	Greenfield	Hancock
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, A. L. (H)	Kingman	Fountain- Warren
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratliffe, A. W.	Evansville	Vanderburgh
Rausch, Norman W.	Angola	Steuben

Name	City	County
Rauschenbach, C. W.	Hammond	Lake
Ravdin, Bernard	Evansville	Vanderburgh
Ravdin, Marcus (H)	Evansville	Vanderburgh
Rawles, Lyman T.	Ft. Wayne	Allen
Rawlins, Carolyn M.	Hammond	Lake
Ray, H. A.	Ft. Wayne	Allen
Rayl, C. C.	Decatur	Adams
Reck, J. L.	Sheridan	Hamilton
Records, A. W.	Franklin	Johnson
Reed, Ann	Michigan City	LaPorte
Reed, Donald	Culver	Marshall
Reed, J. V.	Indianapolis	Marion
Reed, Nelle C.	Michigan City	LaPorte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Indianapolis	Marion
Reed, R. R.	Anderson	Marion
Reed, Wm. C.	Bloomington	Owen- Monroe
Reeder, H. H.	Jeffersonville	Clark
Rees, Russell C.	Indianapolis	Marion
Reese, Thomas V.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Chas. A.	Indianapolis	Marion
Reid, Robert W.	Union City	Randolph
Reilly, James F.	Vincennes	Knox
Reisler, Simon	Indianapolis	Marion
Reiss, Jack	Indianapolis	Marion
Reitz, Thomas F.	Evansville	Vanderburgh
Remich, A. C.	Hammond	Lake
Renbarger, L. L.	Marion	Grant
Rendel, D. T.	Hammond	Lake
Rendel, H. E.	Mexico	Miami
Reppert, Roland L.	Decatur	Adams
Rettig, A. C.	Muncie	Delaware- Blackford
Reusser, Amos (H)	Berne	Adams
Reynolds, D. M.	Garrett	DeKalb
Reynolds, J. S.	Gary	Lake
Reynolds, R. P.	Garrett	DeKalb
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, A. P.	Wabash	Wabash
Rhamy, Mary E.	Bloomington	Owen- Monroe
Rhea, G. D.	Greencastle	Putnam
Rhea, James C.	Beech Grove	Marion
Rhind, A. W.	Hammond	Lake
Rhodes, A. H.	Princeton	Gibson
Rhodes, Theodore D.	Indianapolis	Marion
Rhorer, H. M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rice, Raymond M.	Indianapolis	Marion
Rice, Thurman B.	Indianapolis	Marion
Rice, T. R. (H)	Petersburg	Pike
Rice, W. B.	Ft. Wayne	Allen
Richard, Norman F.	Shelbyville	Shelby
Richards, D. H. (H)	Vincennes	Knox
Richards, E. E.	Russellville	Montgomery
Richardson, C. L.	Rochester	Fulton
Richardson, Thad T.	Indianapolis	Marion
Richart, J. V.	Terre Haute	Vigo
Richer, O. H.	Warsaw	Kosciusko
Richey, Clifford	Evansville	Vanderburgh
Richter, Arthur B.	Indianapolis	Marion
Richter, Samuel	Gary	Lake
Ricketts, J. W.	Indianapolis	Marion
Ridenour, D. C. (H)	Peru	Miami
Ridgway, Alton H.	Belgian Congo, Africa	Marion
Ridgeway, O. W.	Indianapolis	Marion
Rifner, E. S.	Van Buren	Grant
Rigg, J. F.	Indianapolis	Marion
Riggs, Floyd	Terre Haute	Vigo
Rigley, E. L.	South Bend	St. Joseph
Riley, Frank	Jamestown	Boone
Ringenberg, Jordan	Gary	Lake

Name	City	County	Name	City	County
Rininger, Harold C.	Evansville	Vanderburgh	Roth, Bertram	Clayton, Mo.	Delaware-Blackford
Rinker, E. B.	Indianapolis	Marion	Roth, James	Wolf Lake	Noble
Rinne, John I.	Lapel	Madison	Rothberg, Maurice	Ft. Wayne	Allen
Ripley, John W.	Seymour	Jackson	Rothrock, Philip W.	Lafayette	Tippecanoe
Rissing, Walter J.	Ft. Wayne	Allen	Rothschild, C. J.	Ft. Wayne	Allen
Ritchey, J. O.	Indianapolis	Marion	Rotman, Harry G.	Jasonville	Greene
Ritchie, John W.	Monterey Park, Calif.	Delaware-Blackford	Rotman, Sam	Jasonville	Greene
Ritteman, George W.	Columbus	Bartholomew-Brown	Row, D. H.	Indianapolis	Marion
Ritter, Wayne L.	Indianapolis	Marion	Row, George S.	Osgood	Ripley
Ritz, Albert S.	Evansville	Vanderburgh	Row, Perrie Q.	Hammond	Lake
Rivers, Glynn A.	Muncie	Delaware-Blackford	Rowe, Howard H.	Rochester	Fulton
Robb, John A.	Indianapolis	Marion	Royster, George M.	Evansville	Vanderburgh
Robertson, A. N.	New Albany	Floyd	Royster, Robert A.	Evansville	Vanderburgh
Robertson, D. W. (H)	Deputy	Jennings	Rozelle, Clarence V.	Anderson	Madison
Robertson, James S.	Plymouth	Marshall	Rubens, Eli	South Bend	St. Joseph
Robertson, M. O.	Bedford	Lawrence	Rubin, Gerald S.	Indianapolis	Marion
Robertson, Ray	Indianapolis	Marion	Rubin, M. R.	Gary	Lake
Robertson, W. C.	Shipshewana	LaGrange	Rubin, Milton M.	Terre Haute	Vigo
Robertson, W. S.	Spiceland	Henry	Rubin, Simon S.	Gary	Lake
Robinson, Earl U.	Evansville	Vanderburgh	Ruby, Fred McKemy	Union City	Randolph
Robinson, Walter K.	Gary	Lake	Ruddell, Karl R.	Indianapolis	Marion
Robison, C. A.	Frankfort	Clinton	Ruddell, Keith R.	Indianapolis	Marion
Robison, J. S.	Winchester	Randolph	Ruddick, H. C.	Evansville	Vanderburgh
Robrock, Lawrence M.	Michigan City	LaPorte	Rudensky, Herman	Indianapolis	Marion
Rockey, Noah A.	Ft. Wayne	Allen	Rudesill, C. L.	Indianapolis	Marion
Rodenbeck, Frank	Arcadia	Hamilton	Rudolph, Carl J.	South Bend	St. Joseph
Rodin, Herman H.	South Bend	St. Joseph	Rudolph, F. G.	Hammond	Lake
Rodriguez, Juan	Ft. Wayne	Allen	Rudolph, Stephen, Jr.	Indianapolis	Marion
Rogers, Evered E.	Auburn	De Kalb	Rudser, D. H.	Whiting	Lake
Rogers, O. F.	Bloomington	Owen-Monroe	Runge, Paul W.	Richmond	Wayne-Union
Rogers, R. C. (H)	Bloomington	Owen-Monroe	Rupel, Ernest	Indianapolis	Marion
Rogers, Thomas P.	Long Beach, Calif.	Marion	Rusche, Henry J.	Evansville	Vanderburgh
Rohrer, J. R.	Elnora	Daviess-Martin	Ruschli, E. B.	Lafayette	Tippecanoe
Roll, E. C.	Seattle, Wash.	Marion	Rusk, Hubert M.	Wallace	Fountain-Warren
Roller, C. W.	Indianapolis	Marion	Russell, O. Raymond	Noblesville	Hamilton
Rollins, Russell	Royal Center	Cass	Russell, Richard H.	Indianapolis	Pulaski
Romberger, Floyd T.	Lafayette	Tippecanoe	Rust, Byron K.	Indianapolis	Marion
Romberger, Floyd T., Jr.	Indianapolis	Marion	Ruth, Martin L.	Indianapolis	Marion
Rommel, Clarence H.	W. Lafayette	Tippecanoe	Rutherford, C. W.	Indianapolis	Marion
Ropp, E. R.	Oakland City	Gibson	Ryan, Glen V.	Indianapolis	Marion
Ropp, H. E.	New Harmony	Posey	Ryan, H. J.	Gary	Lake
Rose, Bertha	W. Lafayette	Tippecanoe	Ryan, William J.	Columbus	Bartholomew-Brown
Rose, Stuart W.	Muncie	Delaware-Blackford	Ryan, William J. J.	Ft. Wayne	Allen
Rosenak, Bernard D.	Indianapolis	Marion	S		
Rosenbaum, David	Indianapolis	Marion	Sacks, Harry J.	Indianapolis	Marion
Rosenbaum, Irving	Indianapolis	Marion	Sage, Charles V., Jr.	Richmond	Wayne-Union
Rosenbaum, L. E.	Anderson	Madison	Sage, Russell	Indianapolis	Marion
Rosenblatt, B. B.	Evansville	Vanderburgh	Sagel, Jacob	Gary	Lake
Rosenbloom, P. J.	Gary	Lake	Sahlman, Hans	Ft. Wayne	Allen
Rosenfeld, Norman B.	Clinton	Parke-Vermillion	Saide, Robert A.	Michigan City	LaPorte
Rosenheimer, Geo. M.	South Bend	St. Joseph	Sala, J. J.	Gary	Lake
Rosenwasser, Jacob	Boston, Mass.	St. Joseph	Sala, Walter R.	Gary	Lake
Roser, A. J.	Ft. Wayne	Allen	Salb, John A.	Indianapolis	Marion
Rosevear, Henry J.	Hammond	Lake	Salb, Leo A.	Jasper	Dubois
Ross, Alexander T.	Indianapolis	Marion	Salb, Max C.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe	Sales, Louis M.	Lake City, Fla.	Marion
Ross, Guy E.	Anderson	Madison	Salkin, Irwin	Indianapolis	Marion
Ross, H. P.	Richmond	Wayne-Union	Salon, Harry W.	Ft. Wayne	Allen
Ross, James S.	Richmond	Wayne-Union	Salon, N. L.	Ft. Wayne	Allen
Ross, L. F.	Richmond	Wayne-Union	Salzman, Morris	Indianapolis	Marion
Ross, W. W.	LaPorte	LaPorte	Sanders, Harry M.	Indianapolis	Marion
Rossiter, D. L.	Ft. Wayne	Allen	Sanders, I. M. (H)	Greensburg	Decatur
Rossow, Russell J.	Evansville	Vanderburgh	Sanders, J. A.	Auburn	De Kalb
			Sanderson, R. B.	South Bend	St. Joseph
			Sandock, Isadore	South Bend	St. Joseph
			Sandock, Louis	South Bend	St. Joseph
			Sandorf, M. H.	Indianapolis	Marion
			Sandoz, Harry	South Bend	St. Joseph
			Sandoz, Louis A.	South Bend	St. Joseph
			Sandy, Wm. A.	Marion	Grant

Name	City	County	Name	City	County
Saunders, J. L.	Newport	Parke-Vermillion	Scott, George E.	Indianapolis	Delaware-Blackford
Savage, A. R.	Ft. Wayne	Allen	Scott, H. V.	Ft. Wayne	Allen
Savery, C. E.	South Bend	St. Joseph	Scott, Irvin H.	Sullivan	Sullivan
Sayers, F. E.	Terre Haute	Vigo	Scott, I. W.	Indianapolis	Marion
Scales, A. B.	Pickston, S. Dak.	Vanderburgh	Scott, R. F.	Kokomo	Howard
Scamahorn, Malcolm O.	Pittsboro	Hendricks	Scott, R. O.	Charlottesville	Hancock
Scamahorn, O. T.	Pittsboro	Hendricks	Scott, S. L.	Indianapolis	Marion
Scea, Wallace A.	Elwood	Madison	Scott, V. Brown	Shelbyville	Shelby
Schaaf, Alvin	Jamestown	Boone	Scudder, A. N.	Brownsburg	Hendricks
Schaefer, C. R. (H)	Indianapolis	Marion	Scudder, J. A.	Edwardsport	Knox
Schafer, Donald W.	Ft. Wayne	Allen	Seal, Perry F.	Brookville	Fayette-Franklin
Schafer, William C.	Washington	Daviess-Martin	Seale, Joseph	Fairmount	Grant
Schaible, E. L.	Gary	Lake	Seaman, C. F.	Indianapolis	Marion
Schantz, Richard	Remington	Jasper-Newton	Sears, M. Maywood	Elkhart	Elkhart
Schauwecker, Cleon M.	Greencastle	Putnam	Seaton, Albert	Indianapolis	Marion
Schechter, John S.	Indianapolis	Marion	Sedam, Herbert L.	Indianapolis	Marion
Schechter, William J.	Indianapolis	Marion	Sears, Don	Odon	Daviess-Martin
Scheetz, Marion R.	Lewisville	Henry	Segar, Louis H.	Indianapolis	Marion
Scheier, E. W.	Indianapolis	Marion	Seibel, Robert M.	Morgantown	Morgan
Schell, Harry D.	Bloomington	Owen-Monroe	Selby, K. E.	South Bend	St. Joseph
Schellhouse, Earl M.	Ft. Wayne	Allen	Selsam, Etta B.	Terre Haute	Vigo
Schenck, Foss	Logansport	Cass	Senese, T. J.	Gary	Lake
Schenk, G. H.	Ridgeville	Randolph	Sennett, C. M.	South Bend	St. Joseph
Scherb, Burton E.	Terre Haute	Vigo	Sennett, Wm. K.	Macy	Miami
Scherschel, John P.	Bedford	Lawrence	Sensenich, R. L.	South Bend	St. Joseph
Schetgen, Joseph V.	Geneva	Adams	Senseny, Herbert	Ft. Wayne	Allen
Scheurich, Virgil	Oxford	Benton	Seward, G. W.	N. Manchester	Wabash
Schick, Martin F. (H)	Ft. Wayne	Allen	Sexson, Hiram	Indianapolis	Marion
Schiller, Herbert A.	South Bend	St. Joseph	Seybert, J. D.	Kendallville	Noble
Schirmer, Robert H.	Evansville	Vanderburgh	Seyler, Anna G.	Crown Point	Lake
Schlademan, Karl R.	Ft. Wayne	Allen	Seyler, Paul G.	New Albany	St. Joseph
Schlegel, Edward H.	Ft. Wayne	Allen	Shafer, J. W.	Lafayette	Tippecanoe
Schlemmer, George H.	Warsaw	Kosciusko	Shafer, Marion R.	Indianapolis	Marion
Schlesinger, Daniel	Hammond	Lake	Shafer, Richard H.	Alexandria	Madison
Schlesinger, Jacob	Hammond	Lake	Shaffer, K. L.	Vincennes	Knox
Schlicker, A. G. (H)	Spencer	Lake	Shallenberger, H. R.	Modoc	Randolph
Schlosser, H. C.	Elkhart	Elkhart	Shanklin, E. M.	Hammond	Lake
Schmiedicke, P. H.	Williamsport	Tippecanoe	Shanklin, V. A.	Terre Haute	Vigo
Schmitt, Richard K.	Columbus	Bartholomew-Brown	Shanks, Ray W.	Noblesville	Hamilton
Schmoll, Robert J.	Ft. Wayne	Allen	Shanks, Roy E.	Rushville	Rush
Schneider, Carl J.	Indianapolis	Marion	Shapiro, Joseph	East Chicago	Lake
Schneider, C. P.	Evansville	Vanderburgh	Sharman, Edward J.	Madison	Jefferson
Schneider, Kenneth	Nashville	Bartholomew-Brown	Sharp, John L.	Crawfordsville	Montgomery
Schneider, Louis A.	Ft. Wayne	Allen	Sharp, W. L.	Anderson	Madison
Schoen, Frederic L.	Ft. Wayne	Allen	Shattuck, John C.	Brazil	Clay
Schoolfield, Wm. E.	Orleans	Orange	Sheehan, Francis G.	Indianapolis	Marion
Schott, Edward J.	Terre Haute	Vigo	Sheek, Kenneth I.	Greenwood	Johnson
Schreiner, John E.	Bremen	Marshall	Sheller, Thomas G.	Argos	Marshall
Schriefer, V. V.	Evansville	Vanderburgh	Shellhouse, Michael	Gary	Lake
Schroeder, Henry	Washington	Marion	Shelly, Edward	South Bend	St. Joseph
Schuchman, Gabriel	Indianapolis	Marion	Shenk, E. M.	Kokomo	Howard
Schuldt, T. S.	Piercetown	Kosciusko	Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Schuler, R. P.	Kokomo	Howard	Sheridan, Joseph L.	Wash., D. C.	Marion
Schulhof, M. G.	Muncie	Delaware-Blackford	Sherman, Robert M.	Bluffton	Wells
Schulz, C. H.	Lagrange	Lagrange	Sherster, Harry	Indianapolis	Marion
Schulze, Hans A.	Indianapolis	Marion	Shields, Harry A.	Washington	Daviess-Martin
Schulze, Wm.	Vincennes	Knox	Shields, Jack E.	Brownstown	Marion
Schumaker, Robert A.	Terre Haute	Vigo	Shields, Tom S.	Richmond	Wayne-Union
Schuman, Edith B.	Bloomington	Owen-Monroe	Shinabery, Lawrence	Ft. Wayne	Allen
Schuster, Dwight W.	Indianapolis	Marion	Shively, John L.	Hagerstown	Henry
Schutt, J. B.	Ligonier	Noble	Shobe, Walter R.	Indianapolis	Marion
Schwartz, Fred C.	Kokomo	Howard	Sholty, W. M.	Lafayette	Tippecanoe
Schwartz, W. D. (H)	Portland	Jay	Shonk, Harold W.	Noblesville	Hamilton
Schweitzer, Ada E. (H)	Indianapolis	Marion	Short, John	Ft. Wayne	Allen
Scodel, Benson	Butlerville	Jennings	Shortridge, W. H.	Seymour	Jackson
Scoins, W. H.	Ft. Wayne	Allen	Shoup, H. B.	Greentown	Howard
Scott, Charles C.	Shelbyville	Shelby	Showalter, John P.	Waterloo	DeKalb
Scott, Frank M.	South Bend	St. Joseph	Showalter, John R.	Terre Haute	Vigo
Scott, G. D.	Sullivan	Sullivan	Shrock, E. E.	Amboy	Miami

Name	City	County	Name	City	County
Shuck, Wm. A.	Indianapolis	Marion	Smith, Paul E.	Ellettsville	Owen-Monroe
Shugart, Joseph D.	Indianapolis	Marion	Smith, R. A.	New Castle	Henry
Shullenberger, W. A.	Indianapolis	Marion	Smith, R. D. (H)	Bloomington	Owen-Monroe
Shulruff, H. I.	East Chicago	Lake	Smith, R. Lee	Osgood	Ripley
Shultz, H. M.	Logansport	Cass	Smith, Richard B.	New Haven	Allen
Shumacker, Jr., H. B.	Indianapolis	Marion	Smith, Roger C.	New Haven	Allen
Sicks, O. W.	Indianapolis	Marion	Smith, Roy L.	Indianapolis	Marion
Siebenmorgen, Louis	Terre Haute	Vigo	Smith, Samuel J.	Vincennes	Knox
Siebenmorgen, Paul	Terre Haute	Vigo	Smith, T. J.	Whiting	Lake
Siekerman, C. W.	Indianapolis	Marion	Smith, W. E. (H)	Decatur	Adams
Siekierski, J. M.	Griffith	Lake	Smith, Wilbur F.	Indianapolis	Marion
Siersdorfer, T. N.	Indianapolis	Marion	Smith, William B.	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion	Smithson, Robert A.	Indianapolis	Vanderburgh
Sigmund, Wm. B.	Columbus	Bartholomew-Brown	Smoot, Emory B.	Washington	Daviess-Martin
Silverman, Norman M.	Terre Haute	Vigo	Smoots, S. A.	Terre Haute	Vigo
Silvers, J. M.	Muncie	Delaware-Blackford	Snearly, K. D.	Avilla	Noble
Silvian, Harry	Whiting	Lake	Snider, Byron	Indianapolis	Marion
Simmons, Frederick H.	Marion	Grant	Snively, W. D., Jr.	Evansville	Vanderburgh
Simmons, L. H.	Goshen	Elkhart	Snyder, E. R.	Troy	Perry
Simon, A. R.	LaPorte	LaPorte	Snyder, Morris C.	Richmond	Wayne-Union
Simons, J. S. (H)	Lyons	Greene	Solomon, R. A.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion	Somers, G. H.	Ft. Wayne	Allen
Sims, S. B. (H)	Frankfort	Clinton	Sorenson, Raymond	Kokomo	Howard
Singer, E. C.	Ft. Wayne	Allen	Sosson, Edward	Hammond	Lake
Sink, Frank G.	Remington	Jasper-Newton	Souder, Bonnell M.	Auburn	DeKalb
Sirlin, E. M.	Mishawaka	St. Joseph	Sourwine, C. C.	Brazil	Clay
Sisson, Helen M.	Pendleton	Madison	Souter, Martha C.	Indianapolis	Marion
Skeen, E. D.	Gary	Lake	Southard, C. B.	Noblesville	Hamilton
Skillern, P. G.	South Bend	St. Joseph	Sovine, Joe W.,	Indianapolis	Marion
Skomp, Claud E.	Marion	Grant	Spahr, D. E.	Portland	Jay
Skrenty, Stanley	Hammond	Lake	Spahr, John F.	Indianapolis	Marion
Slabaugh, Carlyle B.	Corpus Christi, Tex.	Marion	Spalding, J. J.	Indianapolis	Marion
Slabaugh, J. S.	Nappanee	Elkhart	Spalding, W. L.	Mishawaka	St. Joseph
Slama, George	Gary	Lake	Spangler, Jesse S.	Kokomo	Howard
Slaughter, Howard C.	Evansville	Vanderburgh	Sparks, A. Jerome	Indianapolis	Allen
Slaughter, John	Evansville	Vanderburgh	Sparks, Alan L.	Indianapolis	Marion
Slaughter, Owen L.	Evansville	Vanderburgh	Sparks, Paul W.	Winchester	Randolph
Slick, C. R.	Lynn	Randolph	Spears, John K.	Paoli	Orange
Sloan, H. P.	New Albany	Floyd	Speas, Robert C.	Terre Haute	Vigo
Slocum, Yudel K.	Indianapolis	Grant	Speheger, Benjamin A.	Bedford	Lawrence
Slominski, H. H.	South Bend	St. Joseph	Spellman, F. A.	Gary	Lake
Sloss, I. H.	Terre Haute	Vigo	Spencer, Beaufort A.	Bloomington	Owen-Monroe
Sluss, David H.	Indianapolis	Marion	Spencer, Frederic	Vincennes	Knox
Sluss, John W. (H)	Indianapolis	Marion	Spenner, R. W.	South Bend	St. Joseph
Smallwood, R. B.	Bedford	Lawrence	Spieth, Wm. H.	Lebanon	Boone
Smelser, H. W.	Connersville	Fayette-Franklin	Spigler, James	Terre Haute	Vigo
Smiley, J. H.	Indianapolis	Marion	Spindler, Robert D.	Cedar Lake	Henry
Smith, B. J.	Kingman	Fountain-Warren	Spink, Urbana	Indianapolis	Marion
Smith, Charles G.	Otterbein	Benton	Spinning, Alva (H)	Michigan City	Fountain-Warren
Smith, David J.	Indianapolis	Marion	Spivey, R. J.	Indianapolis	Marion
Smith, D. L.	Indianapolis	Marion	Spolyar, L. W.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion	Sponder, Joseph	Gary	Lake
Smith, Francis C.	Indianapolis	Marion	Spray, Page E.	Elkhart	Elkhart
Smith, Frederick R.	Spencer	Owen-Monroe	Springstun, C. E.	Tennyson	Warrick
Smith, G. A.	New Haven	Allen	Springstun, C. L.	Chrisney	Spencer
Smith, Gloster J.	Kokomo	Howard	Springstun, George	Oaktown	Knox
Smith, H. N.	Brookville	Fayette-Franklin	Springstun, W. R.	Evansville	Vanderburgh
Smith, H. S.	Bloomington	Owen-Monroe	Spurlock, Fae	West Lafayette	Tippecanoe
Smith, James M.	Indianapolis	Marion	Spurgeon, O. E.	Muncie	Delaware-Blackford
Smith, James S.	Muncie	Delaware-Blackford	Sputh, Carl B., Sr.	Indianapolis	Marion
Smith, John R.	Richmond	Wayne-Union	Sputh, Carl B., Jr.	Indianapolis	Marion
Smith, L. C.	Lafayette	Tippecanoe	Stadler, Harold E.	Indianapolis	Marion
Smith, L. W.	Warren	Huntington	Staff, Robert A.	Rockville	Parke-Vermillion
Smith, Lester A.	Indianapolis	Marion	Stafford, J. C.	Plainfield	Hendricks
Smith, Louis D.	East Chicago	Lake	Stafford, W. C.	Plainfield	Hendricks
Smith, Marsh H.	W. Lafayette	Tippecanoe	Stahl, Edward	Lafayette	Tippecanoe

Name	City	County	Name	City	County
Stalter, Gaylord W.	North Webster	Kosciusko	Stoycoff, C. M.	Gary	Lake
Stamper, J. H.	Middletown	Madison	Strange, J. W.	Loogootee	Daviess-Martin
Stamper, L. Allen	Richmond	Wayne-Union	Strange, Martin B.	New Albany	Floyd
Stangle, W. J.	Bloomington	Owen-Monroe	Straughn, Walter L.	Crawfordsville	Montgomery
Stanley, John R.	Muncie	Delaware-Blackford	Straus, David C.	Michigan City	LaPorte
Stanley, J. S.	Indianapolis	Marion	Strayer, J. W.	Lafayette	Tippecanoe
Stanton, J. J.	Logansport	Cass	Streck, F. A.	Lawrenceburg	Dearborn-Ohio
Stauffer, George E.	Mooreland	Henry	Streepey, J. I.	New Albany	Floyd
Stauffer, Richard C.	Ft. Wayne	Allen	Streib, Homer F.	Portland	Jay
Stauffer, Walter A.	Elkhart	Elkhart	Strickland, Karl S.	Princeton	Gibson
Staunton, Henry A.	St. Joseph Bend	St. Joseph	Strickland, Martha B.	Lafayette	Tippecanoe
Stayton, C. A.	Indianapolis	Marion	Strickland, Wm. B.	Mitchell	Lawrence
Stayton, Chester A., Jr.	Rochester, Minn.	Marion	Strong, Daniel S.	Terre Haute	Vigo
Stecy, Peter	Whiting	Lake	Stroup, Tyler J.	Indianapolis	Marion
Steele, Brandt F.	Philadelphia, Pa.	Marion	Stubbins, William M.	Elkhart	Elkhart
Steele, D. J.	Greencastle	Putnam	Stuckman, E. N. (H)	New Paris	Elkhart
Steele, E. B.	Crown Point	Lake	Stucky, Ellsworth	Indianapolis	Marion
Steele, Paul W.	Indianapolis	Marion	Stultz, Q. F.	Ligonier	Noble
Steffen, A. J.	Wabash	Wabash	Stump, Thomas A.	Indianapolis	Marion
Steffen, J. T.	Wabash	Wabash	Sturgis, Donald G.	Sellersburg	Clark
Steinkamp, E. F.	Huntingburg	Dubois	Stygall, J. H.	Indianapolis	Marion
Steinman, H. E.	Monroeville	Allen	Sudranski, Herbert F.	Indianapolis	Marion
Stellner, Howard A.	Ft. Wayne	Allen	Sugarman, Benj. E.	French Lick	Orange
Stemm, W. H. (H)	North Vernon	Jennings	Sullenger, A. A.	Marion	Grant
Stephens, Donald E.	Indianapolis	Marion	Sullivan, John M.	Terre Haute	Vigo
Stephens, K. H.	Indianapolis	Marion	Sullivan, T. L.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren	Sutter, Charles C.	Evansville	Vanderburgh
Stephens, R. Clarence (H)	Plymouth	Marshall	Sutton, Wm. E.	Indianapolis	Marion
Stephenson, L. E.	Michigan City	LaPorte	Suverkrup, Lotta R. A.	Columbus	Bartholomew-Brown
Stempleton, John D.	Richmond	Wayne-Union	Swan, John R.	Indianapolis	Marion
Stern, Nathan	Indianapolis	Marion	Swan, Richard Carl	Anderson	Madison
Stern, S. L.	Hammond	Lake	Swank, L. Forrest	Elkhart	Elkhart
Sterne, John H.	Evansville	Marion	Swayne, J. F.	Indianapolis	Marion
Stevens, S. L.	Indianapolis	Marion	Sweet, Austin D.	Martinsville	Morgan
Stewart, C. S. (H)	Auburn	DeKalb	Sweet, Howard E.	Richmond	Wayne-Union
Stewart, Milton B.	Logansport	Cass	Swihart, Homer D.	Elkhart	Elkhart
Stewart, O. H.	Aurora	Dearborn-Ohio	Swihart, L. F.	Elkhart	Elkhart
Stewart, W. E.	Terre Haute	Vigo	Switzer, Robert E.	Denver, Colorado	Noble
Stier, Paul L.	Ft. Wayne	Allen	Symmes, Alfred T.	Indianapolis	Marion
Stimson, Harry R.	Gary	Lake	T		
Stine, Marshall E.	Bremen	Marshall			
Stinson, A. E.	Rochester	Fulton	Take, J. F. (H)	French Lick	Orange
Stinson, Dean K.	Rochester	Fulton	Talbert, Pierre C.	Ft. Wayne	Allen
Stiver, Daniel	South Bend	St. Joseph	Talbot, Dan E.	Indianapolis	Marion
Stocking, B. W.	Muncie	Delaware-Blackford	Tanner, Henry S.	Indianapolis	Marion
Stoelting, J. Lewis	Terre Haute	Vigo	Taylor, C. C.	Indianapolis	Marion
Stoelting, V. K.	Indianapolis	Marion	Taylor, E. C.	Upland	Grant
Stoen, H. J.	Lafayette	Tippecanoe	Taylor, Eugene C.	Evansville	Vanderburgh
Stoler, A. E.	Ft. Wayne	Allen	Taylor, F. W.	Indianapolis	Marion
Stone, A. T.	Indianapolis	Marion	Taylor, James A. (H)	Montpelier	Delaware-Blackford
Stone, Charles E.	Bedford	Lawrence	Taylor, J. E. (H)	Leopold	Perry
Stone, David F.	Indianapolis	Marion	Taylor, L. S.	Elberfeld	Warrick
Stoops, Jean T.	Wabash	Wabash	Taylor, W. H.	Ambia	Benton
Storer, Wm. R.	Hobart	Lake	Taylor, W. M.	Crawfordsville	Montgomery
Storey, D. E.	Indianapolis	Marion	Taylor, W. R.	Richmond	Wayne-Union
Storey, Joseph L.	Indianapolis	Marion	Teaford, S. F.	Paoli	Orange
Stork, Harvey K.	Huntingburg	Dubois	Teague, Frank	Indianapolis	Marion
Stork, Urban	Evansville	Vanderburgh	Teal, Dorothy D.	Columbus	Bartholomew-Brown
Storms, Roy B.	Indianapolis	Marion	Teegarden, J. A., Jr.	East Chicago	Lake
Stouder, Albert E.	Kempton	Tipton	Teegarden, J. A., Sr.	East Chicago	Lake
Stouder, C. E.	Gosport	Owen-Monroe	Teeter, E. J.	Goodland, Kan.	Marion
Stout, Harry T.	Colfax	Clinton			
Stout, R. B.	Elkhart	Elkhart			
Stout, Walter M.	New Castle	Henry			
Stover, Raymond M.	Francesville	Pulaski			
Stover, W. C.	Boonville	Warrick			

Name	City	County	Name	City	County
VanNuys, John D.	Indianapolis	Marion	Warren, Ward	Terre Haute	Vigo
VanNuys, W. C.	New Castle	Henry	Warrick, Francis B.	Richmond	Wayne- Union
VanOsdol, H. A.	Indianapolis	Marion	Warrick, Homer L.	Osceola	St. Joseph
Van Rie, L. P.	Mishawaka	St. Joseph	Warriner, James B.	Indianapolis	Marion
VanSandt, F. A.	Bloomfield	Greene	Warvel, J. H.	Indianapolis	Marion
VanTassel, Charles J.	Indianapolis	Marion	Warvel, J. L. (H)	N. Manchester	Wabash
VanVactor, Helen D.	Indianapolis	Marion	Washburn, W. W.	Lafayette	Tippecanoe
VanWinkle, Arthur J.	Valparaiso	Porter	Wasley, Malcolm T.	Muncie	Delaware- Blackford
Veach, Lester W.	Bainbridge	Putnam	Waterman, John H.	Indianapolis	Marion
Veach, Richard L.	Bainbridge	Putnam	Waymire, E. S.	Indianapolis	Marion
Veazey, Wm. (H)	Avilla	Noble	Weathers, Paul E.	Ft. Dix, N. J.	Marion
Venable, George L.	N. Manchester	Wabash	Weaver, T. M. (H)	Brazil	Clay
Venis, Kemper N.	Muncie	Delaware- Blackford	Weaver, Wm. W.	New Albany	Floyd
Verplank, G. L.	Gary	Lake	Webb, Harry	Anderson	Madison
Viehe, Robert W.	Evansville	Vanderburgh	Weber, Edgar H.	Evansville	Vanderburgh
Viehe, Robert W., Jr.	Muncie	Delaware- Blackford	Weber, John R.	Ft. Wayne	Allen
Vietzke, P. C. F.	Valparaiso	Porter	Weber, Joseph G. S.	Terre Haute	Vigo
Viney, Charles L.	Logansport	Cass	Webster, R. K.	Brazil	Clay
Visher, John S.	Evansville	Vanderburgh	Weddle, Chas. O.	Lebanon	Boone
Visher, John W.	Evansville	Vanderburgh	Weeks, P. H.	Michigan City	LaPorte
Vlaskamp, Elaine	Muncie	Delaware- Blackford	Weems, M. P.	Jeffersonville	Clark
Vogel, L. John	Mt. Vernon	Posey	Wegner, W. G. (H)	South Bend	St. Joseph
Voges, Edward C.	Terre Haute	Vigo	Wehrman, J. O.	Indianapolis	Marion
Voisinet, R. A.	Union City	Randolph	Weigand, C. G.	Indianapolis	Marion
VonAsch, George	LaPorte	LaPorte	Weil, H. J.	Indianapolis	Marion
Vollrath, Victor J.	Indianapolis	Marion	Weiland, Albert S.	East Chicago	Lake
Vore, Hugh A.	East Chicago	Lake	Weinberg, B. A.	Whiting	Lake
Vore, L. W.	Plymouth	Marshall	Weinberg, Samuel	Marion	Grant
Voyles, C. F. (H)	Indianapolis	Marion	Weinland, George C.	Indianapolis	Marion
Voyles, Harry	New Albany	Floyd	Weinstein, E. B.	Richmond	Wayne- Union
Vracin, Daniel	Downey, Calif.	Lake	Weinstein, J. H.	Terre Haute	Vigo
Vye, James P.	Gary	Lake	Weinstein, Louis	Marion	Grant
W			Weinstock, Adolph	Rolling Prairie	LaPorte
Wade, A. A.	Howe	Lagrange	Weirich, Charles I.	Butler	Dekalb
Wadsworth, H. C.	Washington	Daviess- Martin	Weis, William D. (H)	Crown Point	Lake
Wagner, James Marion	Huntingburg	Dubois	Weiskopf, Henry S.	Gary	Lake
Wagoner, G. W.	Delphi	Carroll	Weiss, Eugene	South Bend	St. Joseph
Wagoner, Robert H.	Colburn	Tippecanoe	Weiss, H. G.	Evansville	Vanderburgh
Waite, Earl L.	Gilead	Miami	Weiss, Jason	Indianapolis	Marion
Waite, Richard R.	Lafayette	Tippecanoe	Weitzel, Roland	Princeton	Gibson
Waldo, J. Thayer	Indianapolis	Marion	Welborn, Mell B.	Evansville	Vanderburgh
Wales, E. DeWolfe (H)	Indianapolis	Marion	Weller, Charles A.	Indianapolis	Marion
Walker, Floyd B.	Ft. Wayne	Allen	Weldy, Bryce P.	Hartford City	Delaware- Blackford
Walker, F. C.	Indianapolis	Marion	Wenger, Richard B.	Elkhart	Elkhart
Walker, Jack	Knightstown	Henry	Welty, S. G.	Ft. Wayne	Allen
Walker, J. L.	LaFontaine	Wabash	Werry, L. E.	Hartford City	Delaware- Blackford
Walker, Robert K.	Indianapolis	Marion	Wertemberger, Morris D.	Richmond	Wayne- Union
Walker, Wm. H. (H)	Portland	Jay	Wesson, Thomas W.	Evansville	Vanderburgh
Wall, Joseph A.	Wabash	Wabash	West, Joseph L.	Indianapolis	Marion
Wallace, Hawthorne C.	Crawfordsville	Montgomery	Westerbeck, Charles W.	St. Meinrad	Perry
Wallace, J. C.	Ft. Wayne	Allen	Westfall, B. Kemper	Indianapolis	Marion
Waller, John I.	Indianapolis	Marion	Westfall, George S.	Goshen	Elkhart
Walsh, T. P.	Garrett	Dekalb	Westfall, John B.	Indianapolis	Marion
Walters, Charles E.	Mishawaka	St. Joseph	Westmoreland, R. E.	Indianapolis	Marion
Walther, Joseph E.	Indianapolis	Marion	Weyerbacher, A. F.	Indianapolis	Marion
Wanninger, Horace	Richmond	Wayne- Union	Whallon, Arthur J.	Richmond	Wayne- Union
Ward, H. H.	Coalmont	Clay	Wharton, R. O.	Gary	Lake
Ward, J. W.	Mishawaka	St. Joseph	Wheeler, J. T. (H)	Indianapolis	Marion
Ward, Wesley C.	Indianapolis	Marion	Whipps, Charles E.	Carlisle	Sullivan
Ware, J. R.	Huntington	Huntington	Whisler, F. M.	Wabash	Wabash
Warfel, F. C.	Indianapolis	Marion	Whitcomb, Roger F.	Shelbyville	Shelby
Warfield, Chester H.	Ft. Wayne	Allen	White, C. S.	Rosedale	Parke- Vermillion
Warman, A. P.	Indianapolis	Marion	White, Donald J.	Indianapolis	Marion
Warn, William J.	Milan	Ripley	White, Harvey E.	Farmland	Randolph
Warne, G. H.	Tipton	Tipton	White, I. D. (H)	Clinton	Parke- Vermillion
Warren, Bradford	Marshall	Parke- Vermillion			
Warren, Carroll B.	Marion	Grant			
Warren, John C.	Indianapolis	Knox			

Name	City	County	Name	City	County
White, James V.	Terre Haute	Vigo	Windstandley, W. C. (H)	New Albany	Floyd
White, W. J. (H)	Gary	Lake	Winter, Donald K.	Logansport	Cass
Whitehead, John M.	Indianapolis	Marion	Winters, Matthew	Indianapolis	Marion
Whitlatch, Arthur	Milan	Ripley	Wise, Charles L.	Camden	Carroll
Whitlock, Francis C.	Indianapolis	Marion	Wisehart, Wm. (H)	Colfax	Clinton
Whitlock, Merle E.	Mishawaka	St. Joseph	Wiseheart, O. H. (H)	North Salem	Hendricks
Whitsitt, S. A. (H)	Madison	Jefferson	Wiseheart, Robert	Lebanon	Boone
Wicks, O. C. (H)	Gary	Lake	Wiseman, V. Earle	Greencastle	Putnam
Wiedemann, F. E. (H)	Terre Haute	Vigo	Wisener, G. H.	Richmond	Wayne-Union
Wiethoff, Clifford Allen	Indianapolis	Marion	Wishard, Wm. N., Jr.	Indianapolis	Marion
Wiggins, D. S. (H)	New Castle	Henry	Wishart, S. W.	Evansville	Vanderburgh
Wiggins, George	New Castle	Henry	Wissman, William L.	Columbus	Bartholomew-Brown
Wilber, H. R.	Jeffersonville	Clark	Witham, Robert L.	Culver	Marshall
Wilcox, R. F.	LaPorte	LaPorte	Wixted, John F.	Mishawaka	St. Joseph
Wilder, G. B.	Anderson	Madison	Wixted, Julia F.	Mishawaka	St. Joseph
Wiley, William M.	Shelbyville	Shelby	Wohlfeld, J. B.	Bedford	Lawrence
Wildman, R. E.	Peru	Miami	Wolfe, Nelson	New Albany	Floyd
Wilhelm, Agatha M.	South Bend	St. Joseph	Wolfram, Don J.	Indianapolis	Marion
Wilhelmus, C. K.	Evansville	Vanderburgh	Woner, John W.	Linton	Greene
Wilhelmus, Charles M.	Newburgh	Warrick	Wood, Amelia T.	Muncie	Delaware-Blackford
Wilhelmus, Gilbert	Evansville	Vanderburgh	Wood, Donald E.	Indianapolis	Marion
Wilhelmus, Wm. M.	Evansville	Vanderburgh	Wood, E. U. (H)	Columbus	Bartholomew-Brown
Wilkins, I. W.	Indianapolis	Marion	Wood, O. L.	Brazil	Clay
Wilkerson, Edward L.	Terre Haute	Vigo	Wood, R. W.	Oakland City	Gibson
Wilkins, R. W.	Ft. Wayne	Allen	Wood, W. B.	Oakland City	Gibson
Wilkinson, Roger L.	Anderson	Madison	Wood, W. H.	Evansville	Vanderburgh
Willan, H. R.	Martinsville	Morgan	Woodard, Abram S., Jr.	Indianapolis	Marion
Williams, A. H.	Ft. Wayne	Allen	Woodcock, C. E.	Greenwood	Johnson
Williams, Alexander S.	Gary	Lake	Woods, A. L.	Poseyville	Posey
Williams, Berniece	Ft. Wayne	Allen	Woods, H. C.	Markle	Huntington
Williams, Charles D.	Indianapolis	Marion	Woods, James R.	Greenfield	Hancock
Williams, Charles F.	Morganfield, Ky.	Dubois	Woods, Wm. P.	Evansville	Vanderburgh
Williams, C. L.	Marion	Grant	Woolery, R. H.	Bedford	Lawrence
Williams, Everett W.	Columbus	Bartholomew-Brown	Work, Bruce A.	Frankfort	Clinton
Williams, F. M., Jr.	Anderson	Madison	Work, James A., Jr.	Elkhart	Elkhart
Williams, F. P.	Huntingburg	Dubois	Worley, A. C.	Ft. Wayne	Allen
Williams, Frederic N.	Mt. Vernon	Posey	Worley, Henry Lee	Henryville	Clark
Williams, George D.	Chamblee, Georgia	Marion	Worley, J. P.	Indianapolis	Marion
Williams, H. O.	Kendallville	Noble	Worth, C. W.	Milroy	Rush
Williams, Howard S.	Indianapolis	Marion	Wright, Cecil S.	Anderson	Madison
Williams, John H.	Muncie	Delaware-Blackford	Wright, E. D.	Seymour	Jackson
Williams, Luther (H)	Indianapolis	Marion	Wright, J. Wm., Jr.	Indianapolis	Marion
Williams, Paul D.	Martinsville	Morgan	Wright, J. William	Indianapolis	Marion
Williams, R. H.	Anderson	Madison	Wright, W. C.	Ft. Wayne	Allen
Willis, Charles F.	Evansville	Vanderburgh	Wurster, H. C.	Mishawaka	St. Joseph
Willison, George	Evansville	Vanderburgh	Wyatt, Fred H.	Denver, Colorado	Vanderburgh
Wills, Benjamin F.	Union City	Randolph	Wyatt, James L.	Ft. Wayne	Allen
Wills, Max	Auburn	Dekalb	Wyatt, James L., III	Ft. Wayne	Allen
Willson, C. L.	Anderson	Madison	Wyeth, Charles (H)	Terre Haute	Vigo
Wilmore, Ralph C.	Indianapolis	Marion	Wygant, M. D.	Mishawaka	St. Joseph
Wilson, Fred	Terre Haute	Vigo	Wyland, B. J.	Mishawaka	St. Joseph
Wilson, Fred M.	Chicago, Ill.	Howard	Wynn, J. F.	Evansville	Vanderburgh
Wilson, Guy	Bicknell	Knox	Wynne, R. E.	Bedford	Lawrence
Wilson, James	South Bend	St. Joseph	Wytttenbach, Frederick	Indianapolis	Marion
Wilson, John D.	Evansville	Vanderburgh	Wytttenbach, John E.	Indianapolis	Marion
Wilson, L. A.	Michigan City	LaPorte		Y	
Wilson, Leslie	Indianapolis	Allen	Yarling, J. E. (H)	Peru	Miami
Wilson, O. E.	Elkhart	Elkhart	Yarrington, C. W.	Gary	Lake
Wilson, Paul	Boonville	Warrick	Yeck, C. W.	Evansville	Vanderburgh
Wilson, P. H.	Logansport	Cass	Yegerlehner, Roscoe	Kentland	Jasper-Newton
Wilson, R. C.	Franklin	Johnson	Yencer, M. W. (H)	Richmond	Wayne-Union
Wilson, Ralph	Evansville	Vanderburgh	Yochem, August S.	Corydon	Harrison
Wilson, Ronald B.	Ft. Wayne	Allen	Yocum, Boaz (H)	Coal City	Owen-Monroe
Wilson, T. L.	Bloomington	Owen-Monroe			
Wiltshire, J. W. (H)	Bloomington	Owen-Monroe			
Wimmer, G. G.	Huntington	Huntington			
Wimmer, Robert N.	Gary	Lake			
Winebrenner, John D.	Nashville, Tenn.	Bartholomew-Brown			

Name	City	County	Name	City	County
Yocum, P. S.	Gary	Lake	Z		
Yocum, William S.	Gary	Lake	Zallen, S. G.	East Chicago	Lake
Yoder, Albert C.	Goshen	Elkhart	Zaring, B. K.	Columbus	Bartholomew-Brown
Yoder, D. D.	Columbus	Bartholomew-Brown	Zehr, Noah	Ft. Wayne	Allen
Yoder, Richard P.	Bluffton	Wells	Zeiger, Irvin	Morocco	Jasper-Newton
York, Arthur F.	Anderson	Madison	Zell, Evertson H.	Indianapolis	Marion
Younan, Thomas	Fort Jackson, N. C.	Tippecanoe	Zeman, Theodore C.	Hammond	Lake
Young, E. M. (H)	Sheridan	Hamilton	Zerfas, Charles P. A.	Indianapolis	Marion
Young, G. M.	Gary	Lake	Zerfas, L. G.	Camby	Sullivan
Young, G. S.	Muncie	Delaware-Blackford	Zerfas, Phyllis	Indianapolis	Marion
Young, James W.	Indianapolis	Marion	Zierer, R. O.	Anderson	Madison
Young, John M.	Indianapolis	Marion	Zimmer, Henry J.	Mishawaka	St. Joseph
Young, Ralph H.	Goshen	Elkhart	Zimmerman, Harold	Evansville	Vanderburgh
Young, Robert	Marion	Grant	Zink, Robert O.	Vevay	Switzerland
Young, S. J. (H)	Kendallville	Noble	Zivich, John	East Chicago	Lake
Young, W. C.	Indianapolis	Marion	Zix, Geraldine M.	Indianapolis	Marion
Yung, J. Rudolph	Terre Haute	Vigo	Zweig, E. S.	Ft. Wayne	Allen
Yunker, P. E.	Evansville	Vanderburgh	Zwerner, Paul F.	Terre Haute	Vigo
			Zwick, Harold F.	Decatur	Adams
			Zwickel, R. E.	Newburgh	Warrick

ROSTER OF MEMBERS BY COUNTIES

(As of June 1, 1949)

Physicians are listed in the counties in which they reside.

ADAMS COUNTY

Beaver, Norman Berne
 Habegger, Myron L. Berne
 Jones, D. D. (H) Berne
 Lehman, Harold Berne
 Reusser, Amos (H) Berne
 Burk, James M. Decatur
 Carroll, John C. Decatur
 Duke, Benjamin E. Decatur
 Girod, Arthur H. Decatur
 Kohne, Gerald J. Decatur
 Parrish, Richard K. Decatur
 Rayl, Claudius C. Decatur
 Reppert, Roland L. Decatur
 Smith, Waldo E. (H) Decatur
 Terveer, John B. Decatur
 Zwick, Harold F. Decatur
 Hinchman, Clarence P. Geneva
 Schetgen Joseph V. Geneva

ALLEN COUNTY

Fort Wayne

Adams, John R. 621 W. Berry (2)
 Aiken, Arthur F. 1923 E. State
 Aiken, Nevin E. 1923 E. State St.
 Bailey, Paul P.
 206 Wayne Phar. Bldg. (2)
 Baltes, Jos. H. 721 Broadway (2)
 Bartholomew, Alfred C.
 405 Dime Bank Bldg. (2)
 Bash, Wallace E. 111 Esmond
 Baumgartner, J. C.
 618 Wayne Phar. Bldg. (2)
 Beams, Ralph
 517 Wayne Phar. Bldg. (2)
 Beierlein, Karl M.
 334 Wayne Phar. Bldg. (2)
 Benninghoff, D. R.
 208 Wayne Phar. Bldg. (2)

Berghoff, R. J. 306 E. Jefferson (2)
 Bickel, J. E. 2615 S. Lafayette (2)
 Blosser, H. V. (H) 309 W. Main (2)
 Bolman, Ralph M.
 702 Wayne Phar. Bldg. (2)
 Borders, Theodore R.
 1145 S. Lafayette (2)
 Bowers, G. T. 307 E. Jefferson (2)
 Bowers, J. W. 418 Gettle Bldg.
 Brosius, R. H. W. 1603 Wells (7)
 Brown, F. W. 335 Lincoln Bk. Tr.
 Bruggeman, H. O.
 604 Wayne Phar. Bldg. (2)
 Buckner, Doster 421 W. Wayne (2)
 Bulson, Eugene L.
 102 Wayne Phar. Bldg. (2)
 Calvin, J. C. (H) 312 W. Wayne (2)
 Cameron, Don F.
 702 Wayne Phar. Bldg. (2)
 Carey, Willis W. (H)
 2525 S. Calhoun (5)
 Carlo, E. R. 2902 Fairfield (6)
 Cartwright, E. L.
 230 Wayne Phar. Bldg. (2)
 Catlett, M. B. 232 W. Wayne (2)
 Chambers, A. R. 602 W. Wayne (2)
 Clark, J. H. 1525 Oxford St.
 Clark, W. R. 3622 S. Calhoun St.
 Conley, J. E. 620 W. Berry (2)
 Cooney, C. J. 527 W. Berry (2)
 Cornell, B. S. 435 Lincoln Bk. Tr.
 Craig, R. M. 3328 Fairfield Ave.
 Culp, J. E. 2902 Fairfield (6)
 Dancer, C. R. (H)
 228 Wayne Phar. Bldg. (2)
 Ditton, I. W. (H) 1214 E. Wayne (4)
 Duemling, A. H. 2902 Fairfield (2)
 Dunstone, H. C.
 502 Wayne Phar. Bldg. (2)
 Eberly, Karl C.
 310 Wayne Phar. Bldg. (2)

Edlavitch, B. M. 716 Rockhill (2)
 Elston, Lynn W.
 622 Wayne Phar. Bldg. (2)
 Elston, Ralph W.
 622 Wayne Phar. Bldg. (2)
 Estlick, R. E.
 629 Wayne Phar. Bldg. (2)
 Ferguson, A. N. 2902 Fairfield (6)
 Fichman, A. M. 323 W. Berry (2)
 Foy, H. W. 1747 Wells (7)
 Garton, H. W. 3012 Shawnee (6)
 Gerding, W. J. 2638½ S. Calhoun
 Gessler, W. F. 2902 Fairfield (6)
 Gladstone, N. H. 335 W. Berry (2)
 Glock, Homer E.
 324 Wayne Phar. Bldg. (2)
 Glock, M. E. 312 W. Wayne (2)
 Glock, W. R. 312 W. Wayne (2)
 Gould, L. K. 3415 S. Fairfield (6)
 Graham, George M.
 Lincoln Nat. Life Ins. Co.
 Haffner, H. G. 202 E. Jefferson (2)
 Hamilton, E. D. 2405 Florida Dr.
 Harshman, L. P.
 2704 N. Clinton (3)
 Harvey, H. C. 1202 E. State (3)
 Hasewinkle, A. M. 1129 E. State (3)
 Hastings, Warren C.
 Wayne Phar. Bldg. (2)
 Hattendorf, A. P.
 707 Wayne Phar. Bldg. (2)
 Havens, R. E. 1102 Pemberton Dr.
 Heysett, Norman W.
 Irene Byron San., Lima Rd.
 Hoffman, A. F. 1301 W. Main
 Hoffmann, S. P.
 424 Wayne Phar. Bldg. (2)
 Holsinger, Robert E.
 832 E. Creighton (5)
 Horton, G. R. 527 W. Berry St.
 Housley, J. L. 801 E. State Blvd.

ALLEN COUNTY

(Fort Wayne—Continued)

Howe, F. L. 1525 Oxford St.
 Jurgensen, W. T. 3415 Fairfield
 Kent, Richard N.
 731 Wayne Phar. Bldg. (2)
 Kidder, O. T. Irene Byron San.
 Kruse, E. H. 705 Lincoln Tr. (2)
 Kruse, Walter E.
 512 Wayne Phar. Bldg. (2)
 Ladig, D. S. 337 E. Berry (2)
 Lehner, J. J.
 323 Wayne Phar. Bldg. (2)
 Lenk, G. G. 2007 Maumee (4)
 Lloyd, R. P. 2521½ S. Calhoun St.
 Lohman, R. M.
 618 Wayne Phar. Bldg. (2)
 Loudermilk, Jack L.
 525 Wayne Phar. Bldg. (2)
 Martineau, P. C. Luthern Hosp.
 McArdle, E. G. 2201 S. Calhoun (5)
 McCabe, T. E. 1832 S. Calhoun (5)
 McCoy, R. R. 3701 S. Harrison (6)
 McDowell, G. A.
 215 Wayne Phar. Bldg. (2)
 McEachern, Cecil G.
 702 Wayne Phar. Bldg. (2)
 McKeeman, Donald H.
 633 W. Wayne St. (2)
 McKeeman, L. S.
 304 Wayne Phar. Bldg. (2)
 McNairy, Donald J.
 710 Wayne Phar. Bldg. (2)
 Mendenhall, Edgar
 208 Wayne Phar. Bldg. (2)
 Mercer, Samuel R.
 710 Wayne Phar. Bldg. (2)
 Meyer, H. A. 1030 W. Wayne (2)
 Meyer, T. O. 455 Lincoln Tr.
 Michaelis, S. C. 2154 Fairfield (6)
 Miller, C. G. 320 W. Wayne (2)
 Miller, H. P. 1801 S. Lafayette (5)
 Miller, Mahlon F.
 334 Wayne Phar. Bldg. (2)
 Miller, O. J. 324 W. Berry (2)
 Miller, R. H. 511 W. Wayne (2)
 Miller, W. J. 310 E. Washington
 Moats, C. F. 4007 S. Wayne (6)
 Moats, G. E. 421 E. Wayne (2)
 Moravec, A. E. 705 Lincoln Tr. (2)
 Mortenson, L. J.
 214 Wayne Phar. Bldg. (2)
 Mueller, L. W. 3423 S. Wash. (6)
 Murdock, H. L.
 521 Wayne Phar. Bldg. (2)
 Nahrwold, E. W.
 417 Wayne Phar. Bldg. (2)
 Nill, J. H. 1024 S. Barr (2)
 O'Rourke, C. 604 W. Berry (2)
 Oyer, J. H. 2707½ S. Calhoun St.
 Parker, C. B. 1105 S. Harrison St.
 Perrin, K. F. 2701 S. Anthony St.
 Perry, F. G. 2902 Fairfield (6)
 Popp, Milton F.
 610 Wayne Phar. Bldg. (2)
 Porter, Miles F., Jr.
 501 Dime Bank Bldg. (2)
 Prentiss, Nelson H.
 276 Central Bldg. (2)
 Rabson, S. M. St. Joseph Hosp.
 Ranke, John W. Henry (H)
 3112 Beaver Ave. (6)

Rawles, L. T. 3131 Fairfield (6)
 Ray, Herbert A.
 412 Wayne Phar. Bldg. (2)
 Rice, W. B. 1101 E. Pontiac (5)
 Rissing, W. J. 1706 Sherman (7)
 Rockey, N. A. 1222 E. State (3)
 Rodriguez, J. 2902 S. Fairfield (6)
 Roser, A. J. 617 W. Washington
 Rossiter, D. L. 2615½ Calhoun (5)
 Rothberg, Maurice
 712 Wayne Phar. Bldg. (2)
 Rothschild, C. J.
 319 Wayne Phar. Bldg. (2)
 Ryan, W. J. J. 1536 S. Calhoun
 Sahlmann, H. 1320 Broadway (2)
 Salon, H. W. 535 W. Berry (2)
 Salon, Nathan L.
 220 Wayne Phar. Bldg. (2)
 Savage, A. R. 302 W. Berry (2)
 Schafer, D. W. 221 W. Wayne St.
 Schellhouse, Earl M.
 1240 W. Main St. (7)
 Schick, Martin F. (H)
 401 W. Washington (2)
 Schlademan, Karl R.
 516 Wayne Phar. Bldg. (2)
 Schlegel, E. H. 1129 Maumee (4)
 Schmoll, R. J. 604 W. Berry St.
 Schneider, L. H. St. Joseph's Hosp.
 Schoen, Frederic L.
 220 Wayne Phar. Bldg. (2)
 Scoins, W. H. 1301 S. Harrison
 Scott, H. V. 2902 Fairfield (6)
 Senseny, Herbert
 314 Wayne Phar. Bldg. (2)
 Shinabery, L. 1850 Broadway (6)
 Short, J. T. 2902 Fairfield (6)
 Singer, Elmer C.
 310 Wayne Phar. Bldg. (2)
 Somers, Gerald H.
 2506 Lower Huntington Rd. (8)
 Stauffer, R. C. 312 W. Wayne (2)
 Stellner, H. 324 W. Berry St.
 Stier, Paul L.
 304 Wayne Phar. Bldg. (2)
 Stoler, A. E. 278 Central Bldg.
 Talbert, P. C. 2125 Lawndale (3)
 Tennant, D. L. 1832 S. Calhoun
 Terrill, R. W. 455 Lincoln Tr. (2)
 Thimlar, J. W. 602 E. Lewis (2)
 Thompson, H. Irene Byron San.
 Thornton, Walter E.
 Lincoln Nat. Life Ins. Co.
 Titus, P. S. 1103 S. Barr (2)
 Van Buskirk, E. M.
 525 Wayne Phar. Bldg. (2)
 Wallace, J. C. 4003 Harrison
 Walker, Floyd B. 610 E. Pontiac
 Warfield, C. H. St. Joseph Hosp.
 Weber, John R.
 418 Wayne Phar. Bldg.
 Welty, S. G. 2702½ S. Calhoun (5)
 Wilkins, R. W. 2902 Fairfield (6)
 Williams, A. B. 3526 N. Wash. Rd.
 Williams, A. H. 2902 Fairfield (6)
 Wilson, R. B. 1207 S. Lafayette (2)
 Worley, Ansel C.
 317 Wayne Phar. Bldg. (2)
 Wright, Wm. C.
 621 Wayne Phar. Bldg. (2)
 Wyatt, James L. III
 233 E. Jefferson St. (2)
 Wyatt, J. L. 232 E. Jefferson (2)
 Zehr, Noah. 301 W. Creighton (6)
 Zweig, E. S. 344 W. Berry (2)
 Emme, Richard W. Harlan
 Steinman, Henry E. Monroeville

Ulrich, John Monroeville
 Dahling, C. W. New Haven
 Emenhiser, Donald C. New Haven
 Emenhiser, John L. New Haven
 Hoetzer, Eldore M. New Haven
 Smith, Grover A. New Haven
 Smith, Richard B. New Haven
 Smith, Roger C. New Haven
 DeVoe, Kenneth Woodburn
 Moser, Edward. Box 65, Woodburn
 Byerly, Frederick L.
 1182 W. 4th St.,
 Winston-Salem, N. C.
 Chester, Herbert R.
 123 N. Montezuma St.,
 Prescott, Arizona
 Draper, Merlin H.
 Drew Field T. B. Sanitarium,
 Tampa, Fla.
 Havice, Jay F.
 Millbrook No. 56, Lake Lure, N.C.

BARTHOLOMEW-BROWN
COUNTIES

Adler, David L. Columbus
 Beggs, Lowell F. Columbus
 Carpenter, Thomas D. Columbus
 Dagley, Hubert R. Columbus
 Davis, Marvin R. Columbus
 Fisher, Walter S. Columbus
 Hart, Robert B. Columbus
 Hawes, Marvin E. Columbus
 Macy, George W. Columbus
 Marr, Griffith Columbus
 Norton, Harold J. Columbus
 Overshiner, Lyman Columbus
 Ritteman, George W. Columbus
 Ryan, William J. Columbus
 Schmitt, Richard K. Columbus
 Sigmund, William B. Columbus
 Suverkrup, Lotta R. A. Columbus
 Teal, Dorothy D. Columbus
 Williams, Everett W. Columbus
 Wissman, William L. Columbus
 Wood, Elmer U. (H) Columbus
 Yoder, Dewey D. Columbus
 Zaring, Byron K. Columbus
 Delong, O. A. (H) Elizabethtown
 Dudding, Joseph E. Hope
 Schneider, Kenneth Nashville
 Winebrenner, John D.
 166½ Blount Ave.,
 Nashville, Tenn.

BENTON COUNTY

Taylor, Wade H. Ambia
 Atkinson, Charles W. Boswell
 Muller, L. P. Boswell
 Carnes, Wm. M. Earl Park
 Altier, William H. Fowler
 Turley, Verne L. Fowler
 McCabe, James E. Otterbein
 Smith, Charles G. Otterbein
 Parker, Ernest E. Oxford
 Scheurich, Virgil Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H. Jamestown
 Schaaf, Alvin D. Jamestown
 Beckard, Robert J. Lebanon
 Ball, Herma A. Lebanon
 Coons, John D. Lebanon

BOONE COUNTY—(Continued)

Headley, Lloyd M. Lebanon
 Higgins, Otis C. Lebanon
 Honan, Paul R. Lebanon
 Kern, Clarence G. Lebanon
 Porter, Jack Lebanon
 Porter, John R. Lebanon
 Rainey, Everett A. Lebanon
 Spieth, William H. Lebanon
 Weddle, Charles O. Lebanon
 Wiseheart, Robert H. Lebanon
 Bassett, Clancy Thorntown
 Bassett, Margaret A. Thorntown
 Gregg, Edwin E. Thorntown
 Bailey, Lawrence S. Zionsville
 Harvey, Ralph J. Zionsville
 Johns, Elmer D. Zionsville
 Lovett, Harvey Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

VanKirk, John R. Burlington
 Kennedy, Eva N. Camden
 Wise, Charles L. Camden
 Brown, Thomas Delphi
 Crampton, Charles C. (H) Delphi
 Gros, Hubert Delphi
 Wagoner, George W. Delphi
 Adams, Max R. Flora
 Brookie, Roger Wm. Flora
 McLaughlin, James R. Flora
 Mullin, Herbert Y. Rockfield

CASS COUNTY

Dutchess, C. Toney. Galveston

Logansport

Adamski, Michael 408 North St.
 Bailey, Earl W. 212 Fifth St.
 Ballard, Chas. A. 325½ E. Market
 Bradfield, John C. 408 North St.
 Cooper, Thomas L. 408 North St.
 Dasse, R. J. State Hosp.
 Davis, John C. Masonic Temple
 Egan, B. W. 2305 Broadway
 Fitzgerald, Brice E. 2127 North St.
 Hall, Bernard R. 415 North St.
 Hedde, Eugene L. 309 Seventh St.
 Hickman, Warren R. 211 S. Third
 Hillis, Lowell J. 203 S. Third St.
 Hochhalter, M. 307 Barnes Bldg.
 Hogle, F. D. Logansport St. Hosp.
 Holloway, W. A. (H) 201 S. Third
 Holmes, W. W. Masonic Temple
 Jewell, Earl B. 2019 High St.
 Jones, J. Carl. 422 North St.
 Keefe, Thomas L. 216 Ninth St.
 Larson, John A. State Hosp.
 Maxwell, John B. (H)

32½ E. Broadway
 Morrical, Russell S. Fifth St.
 O'Leary, F. T. 94 Eel River Ave.
 Schenk, Foss Logansport St. Hosp.
 Shultz, Harry M. 412 Fourth St.
 Stanton, Jas. J. 220 S. Sixth St.
 Stewart, Milton B. 308½ Fourth St.
 Terflinger, Fred W. 422 North St.
 Viney, Charles L. Masonic Temple
 Wilson, Paul H. 422 North St.
 Winter, Donald K. 422 North St.
 Newcomb, Wm. K. Royal Center
 Rollins, Russell Royal Center
 Flanagan, Estle P. Walton
 Lybrook, Daniel E. Young America

CLARK COUNTY

Bottorff, David Charlestown
 Goodman, Eli Charlestown
 Buckley, Ernest P. Clarksville

Gudenkauf, E. B. Clarksville
 Worley, Henry L. Henryville
 Adair, Samuel L. Jeffersonville
 Bizer, Mier Jeffersonville
 Bruner, Ralph W. Jeffersonville
 Burman, R. G. Jeffersonville
 Burman, Rich. G. Jeffersonville
 Carlberg, Dale Jeffersonville
 Carney, Joel T. Jeffersonville
 Dare, Lee A. Jeffersonville
 Forsee, Norman E. Jeffersonville
 Huoni, John S. Jeffersonville
 Isler, Nathaniel C. Jeffersonville
 Mercer, Herman Jeffersonville
 Reeder, Henry H. Jeffersonville
 Weems, Mallory P. Jeffersonville
 Wilber, Harold R. Jeffersonville
 Regan, George L. Sellersburg
 Sturgis, D. G., Box 156, Sellersburg
 Vandevent, Arthur C. Sellersburg

CLAY COUNTY

Maurer, James F. Brazil
 Maurer, Robert M. Brazil
 Muncie, Henry L. Brazil
 Palm, John M. Brazil
 Shattuck, John C. Brazil
 Sourwine, Clint C. Brazil
 Weaver, Timothy M. (H) Brazil
 Webster, Robert K. Brazil
 Wood, Opal L. Brazil
 Bond, Walter C. Clay City
 Glosson, Jack R. Clay City
 Ward, Harry H. Coalmont

CLINTON COUNTY

Stout, Harry T. Colfax
 Wisheart, William H. (H) Colfax
 Applegate, Albert E. Frankfort
 Beardsley, Frank A. Frankfort
 Beardsley, John Frankfort
 Burroughs, Carrol A. Frankfort
 Carrel, Francis E. Frankfort
 Chittick, Archibald G. Frankfort
 Compton, Charles B. Frankfort
 Dykhuizen, Theodore A. Frankfort
 Erdel, Milton W. Frankfort
 Hammersley, Geo. K. Frankfort
 Hedgecock, Robert A. Frankfort
 Holmes, Claude D. Frankfort
 Holmes, Claude D., Sr. Frankfort
 Jones, William W. Frankfort
 Michael, Isaac E. Frankfort
 Robison, Claude A. Frankfort
 Sims, Stephen B. (H) Frankfort
 VanKirk, John A. Frankfort
 VanKirk, Paul P. Frankfort
 Work, Bruce A. Frankfort
 Clevinger, William G. Kirklint
 Carlyle, Ivan E. Michigantown
 Combs, Nelson B. Mulberry
 Kent, John A. Mulberry
 Grove, Robert H. Rossville
 Ketcham, John S. Rossville

CRAWFORD COUNTY

Gobbel, Novy E. English
 Nolan, Robert English
 Benz, Jesse Marengo
 Johnson, Jess J. Milltown
 Lynch, Otis R. Marengo

DAVIESS-MARTIN COUNTIES

Norton, Horace Crane
 Rohrer, James R. Elnora
 Chattin, Robert E. Loogootee
 Eifert, Elmer E. Loogootee
 Lett, Emory B. Loogootee
 Strange, John W. Loogootee

McCracken, Jacob O. Montgomery
 Coleman, H. G. Odon
 Sears, Don Odon
 Maschmeyer, Robert H. Shoals
 Arthur, N. Maude Washington
 Blazey, Arthur G. Washington
 Burress, Bert O. Washington
 Chattin, Vance J. Washington
 Farris, John J. Washington
 Fox, C. Philip Washington
 Lindsay, Hamlin B. Washington
 McKittrick, Jack Washington
 McKittrick, Wm. O. Washington
 McNaughton, L. M. Washington
 Rang, Arthur A. Washington
 Rang, Robert H. Washington
 Schafer, Wm. C. Washington
 Schroeder, Henry Washington
 Shields, Harry A. Washington
 Smoot, Emory B. Washington

DEARBORN-OHIO COUNTIES

Baker, Leslie M. Aurora
 Duncan, William F. (H) Aurora
 Jackson, John K. Aurora
 Olcott, Charles W. Aurora
 Stewart, Omer H. Aurora
 Treon, James F. Aurora
 McNeeley, Matthew J. Dillsboro
 Elliott, John C. Guilford
 Fagaly, William J. Lawrenceburg
 Houston, Fred D. Lawrenceburg
 Pfeifer, James M. Lawrenceburg
 Streck, Francis A. Lawrenceburg
 Vail, George A. Lawrenceburg
 Fessler, Gordon S. Rising Sun
 Manley, Charles N. Rising Sun
 Fletcher, Charles F. Sunman

DECATUR COUNTY

Tremain, Milton A. Adams
 Acher, Robert P. Greensburg
 Blemker, Russell H. Greensburg
 Callaghan, Winship C. Greensburg
 Dickson, Dale D. Greensburg
 Mahuron, Boyd L. Greensburg
 McKee, Harley S. Greensburg
 Miller, James C. Greensburg
 Morrison, Clyde C. Greensburg
 Morrison, James T. Greensburg
 Mullikin, Clarence W. Greensburg
 Overpeck, Charles Greensburg
 Sanders, Ira M. (H) Greensburg
 Porter, Edward A. Westport

DEKALB COUNTY

Thill, Leonard S. Ashley
 Covell, Harry M. Auburn
 Geisinger, Lewis N. Auburn
 Hines, Archie V. Auburn
 Nugen, Harold Auburn
 Rogers, Evered E. Auburn
 Sanders, Jesse A. Auburn
 Souder, Bonnell M. Auburn
 Stewart, Charles S. (H) Auburn
 Wills, Max Auburn
 Hathaway, Clayton B. Butler
 Weirich, Charles I. Butler
 Jinnings, Loren E. Garrett
 Kantzer, Floyd B. Garrett
 Newton, Robert A. Garrett
 Reynolds, D. Monroe Garrett
 Reynolds, Russell P. Garrett
 Walsh, Thomas P. Garrett
 Coleman, Floyd B. Waterloo
 Showalter, John P. Waterloo
 Van Nest, Willard A.

New Smyrna Beach, Fla.

DELAWARE-BLACKFORD
COUNTIES

Brown, Stewart D. Albany
 Puterbaugh, Karl E. Albany
 Hurley, John R. Daleville
 Tucker, Oral A. Daleville
 Ames, George F. (H) Eaton
 Downard, Leland F. Gaston
 Langsdon, Fred R. Gaston
 Dando, G. H. (H) Hartford City
 Dodds, Jas. U. Hartford City
 Jackson, Dean B. Hartford City
 Hoffman, Herman Hartford City
 Owsley, C. E. M. Hartford City
 Owsley, Guy A. Hartford City
 Parks, George Hartford City
 Weldy, Bryce P. Hartford City
 Werry, Leslie E. Hartford City
 Burns, Paul E. Montpelier
 Douglas, William T. Montpelier
 Taylor, James A. (H) Montpelier

Muncie

Adams, W. B. Ball Mem. Hosp.
 Alvey, C. R. 417 Wysor Bldg.
 Ball, Clay A. 303 W. Adams
 Bibler, Henry E. 311 W. Adams
 Botkin, C. G. 508 W. Jackson
 Botkin, Thos. 1625½ University
 Bowles, J. H. 417 Wysor Bldg.
 Brown, K. T. 247 Johnson Bldg.
 Butterfield, R. M. 315 W. Jackson
 Clauser, E. H. M. 315 S. Jefferson
 Clevenger, J. H. 315 S. Jefferson
 Cole, R. E. 203 West. Res. Bldg.
 Covalt, W. E. 216 S. High St.
 Cure, E. T. 105 West. Res. Bldg.
 Davis, Edgar C. 107 Plaza Bldg.
 Deutsch, Wm. 309 Johnson Bldg.
 Dunn, F. W. 118 S. Franklin
 Funk, John W. 217 W. Charles
 Galliher, M. J. 115 S. Liberty
 Garling, L. C. 420 W. Washington
 Gill, Thos. A. 424 W. Main
 Greiber, M. F. 420 W. Washington
 Gustafson, Milton 920 Riley Rd.
 Hall, Orville A. 514 Wysor Bldg.
 Hayes, T. R. 210 S. High
 Henderson, R. A. 806 W. Main
 High, Ralph L. 420 W. Washington
 Hill, Howard E. 402 W. Jackson
 Hill, Robert E. 215 W. Jackson
 Hostetter, Irwin S. 115 N. Cherry
 Hurley, Anson G. 110 N. Cherry
 Imhof, Jos. D. 206 West. Res. Bldg.
 Kammer, G. C. 420 W. Washington
 Kammer, W. F. 420 W. Washington
 Kemper, A. T. (H) 112 W. Adams
 Kern, C. B. (H) 715 E. Washington
 Kirshman, F. E. 211 S. High
 LaDuron, J. F. 517 S. Liberty
 Leatherman, C. A. 313 E. Howard
 Manifold, H. M. Ball Mem. Hosp.
 Mason, L. R. 401 W. Jackson
 McMichael, R. M. 324 W. Adams
 Molloy, W. J. (H) 310 W. Jackson
 Montgomery, Lall G.

Ball Memorial Hospital

Moore, Thos. C. 110 N. Cherry
 Moore, Wm. C. 110 N. Cherry
 Owens, R. R. 406 West. Res. Bldg.
 Owens, T. R. 202 West. Res. Bldg.
 Quick, Wm. J. 314 E. Washington
 Rettig, Arthur C. 314 W. Jackson
 Rivers, Glynn A. 215½ S. Walnut
 Rose, Stuart W. 310 Winthrop
 Schulhof, M. G. 418 W. Wash.

Silvers, Jas. M. 220 W. Adams
 Smith, Jas. S. 501 Kirby
 Spurgeon, O. E. 310 E. Washington
 Stanley, John R. 3102 Godman
 Stocking, B. W. Ball Mem. Hosp.
 Tindal, E. F. (H) 214 Wysor Bldg.
 Tomlin, Hugh M. 921 W. Main
 Turner, Robt. D. 217 S. Liberty
 Venis, K. N. 101 S. Franklin
 Viehe, R. W., Jr. Ball Mem. Hosp.
 Vlaskamp, E. M. 401 W. Main
 Wasley, Malcolm T. 2010 S. Vine
 Williams, J. H. 306 E. Jackson
 Wood, Amelia T. 2004 Petty Rd.
 Young, G. S. 316 W. Jackson
 Jump, Charles A. Selma
 Moss, Mavor J. Yorktown
 Earl, Max M. 206 E. Chestnut

Louisville, Ky.

McClintock, James A.

Louisville General Hospital,

Louisville, Ky.

Ritchie, Jno. W. 669 W. Reggin St.,

Monterey Park, Calif.

Roth, Bertram 252 S. Brentwood,

Apt. B, Clayton, Mo.

Oster, Ellis Reed Cottage,

Portland, Oregon

DUBOIS COUNTY

Backer, Henry G. Ferdinand
 Take, John F. French Lick
 Blessinger, L. H. Huntingburg
 Bretz, John M. Huntingburg
 Bretz, W. D. Huntingburg
 Lukemeyer, L. C. (H) Huntingburg
 Steinkamp, E. F. Huntingburg
 Stork, Harvey K. Huntingburg
 Wagoner, Jas. M. Huntingburg
 Williams, F. P. Huntingburg
 Blessinger, Paul J. Jasper
 Casper, John P. Jasper
 Casper, Joseph F. Jasper
 Heck, Martin C. Jasper
 Held, George A. Jasper
 Klammer, Charles H. Jasper
 Lukemeyer, St. John Jasper
 Salb, Leo A. Jasper
 Williams, C. E. Morganfield, Ky.

ELKHART COUNTY

Horswell, Richard G. Bristol
 Neidballa, Edward G. Bristol

Elkhart

Bender, Robt. L. 405 S. Second
 Bloom, Geo. R. 506 S. Second
 Bolin, Robt. S. 209 S. Second
 Bowdoin, Geo. E. 515 S. Second
 Compton, W. A. 2225 Greenleaf
 Conklin, R. L. 1906 E. Jackson
 Cormican, H. L. 316 S. Fourth
 Crandall, L. A. Ames Laboratories
 DeDario, L. M. 123 W. Marion
 Dewey, Fred N. (H) 127 N. Fifth
 Elliott, Lloyd A. 405 S. Second
 Fleming, C. F. 121 W. Marion
 Fleming, Justus M. 123 W. Marion
 Grossnickle, George W.

209 Equity Bldg.

Hull, Arthur W. 506 S. Second
 Hunn, Maro F. 415 S. Second
 Kintner, B. E. 132 Monger Bldg.
 Kistner, A. W. 123 W. Marion
 Kistner, J. W. 337 Equity Bldg.
 Koehler, Elmer G. Monger Bldg.
 Lundt, Milo O. 519 S. Second

Markel, Ivan J. 215 W. Franklin
 McKee, H. N. (H)

319 Monger Bldg.

Mendez, Carlos 116 W. Marion
 Miller, H. A. Jr. 314 S. Second
 Miller, Samuel T. 506 S. Second
 Mininger, E. P. 413 W. Franklin
 Mishkin, Irving 209 S. Second
 Norris, Allen A. 208 W. Marion
 Paff, Wm. A. 515 S. Second
 Paine, Geo. E. 419 Modrell
 Pancost, R. H. 218 Equity Bldg.
 Pancost, V. K. 415 S. Second
 Patrick, Glenn B. 417 S. Second
 Schlosser, H. C. 116 W. Marion
 Sears, M. M. 304 Equity Bldg.
 Spray, Page E. 405 S. Second
 Stauffer, W. A. 214 Equity Bldg.
 Stout, R. B. 1501 Greenleaf Blvd.
 Stubbins, Wm. M. 412 S. Second
 Swank, L. F. 315 Equity Bldg.
 Swihart, H. D. 131 W. Marion
 Swihart, L. F. 214 W. Marion
 Todd, David D. 412 S. Second
 Wenger, R. B. 208 W. Marion
 Wilson, O. E. 217 N. Main
 Work, Jas. A., Jr. 412 S. Second

Goshen

Amstutz, H. C. 521 S. Main
 Bartholomew, M. L. 107 S. Fifth
 Bender, C. K. 115 E. Washington
 Eby, Ida L. 131 S. Main
 Freeman, F. M. 109 W. Wash.
 Hostetler, C. M. 304 E. Lincoln
 Kelly, Wm. R. 210 N. Main
 Kinzie, M. Dale Shoots Bldg.
 Lemon, Herbert K. Shoots Bldg.
 Martin, Floyd S. 127 E. Lincoln
 Miller, M. E. Spohn Bldg.
 Simmons, L. H. 208 E. Lincoln
 VanderBogart, Harry E.

31 Shoots Bldg.

Westfall, Geo. S. 214 E. Lincoln
 Yoder, Albert C. 113 S. Fifth
 Young, Ralph H. 113 E. Madison
 Farver, Moses A. Middlebury
 Norris, Ernest B. Middlebury
 Teters, Melvin S. Middlebury
 Chandler, Leon H. Millersburg
 Fleetwood, R. A. Nappanee
 Kendall, Forest M. Nappanee
 Price, Douglas W. Nappanee
 Price, Melvin D. Nappanee
 Price, Willard A. (H) Nappanee
 Slabaugh, Jancy S. Nappanee
 De Fries, John New Paris
 Stuckman, E. N. (H) New Paris
 Amick, Charles L. Wakarusa
 Hannah, Jack W. Wakarusa
 Elliott, Thomas A. 4577 Utopia Dr.,
 New Orleans 20, La.

FAYETTE-FRANKLIN
COUNTIES

Foreman, Walter A. Brookville
 Glaser, Edward M. Brookville
 Glaser, Robert E. Brookville
 Hoeger, Hobart R. Brookville
 Seal, Perry F. Brookville
 Smith, Herbert N. Brookville
 Ashworth, Lewis N. Connersville
 Booher, Irvin E. Connersville
 Dale, Maxwell H. Connersville
 Elliott, Roy Howe Connersville
 Ellis, George M. Connersville

FAYETTE-FRANKLIN COUNTIES—(Continued)

Entner, Charles L. Connersville
Gordin, Stanley B. Connersville
Gordin, S. E. (H) Connersville
Gregg, Albert F. Connersville
Kemp, William A. Connersville
Lockhart, Jack M. Connersville
Morrow, Roy D. Connersville
Mountain, Francis B. Connersville
Neukamp, Frank H. Connersville
Smelser, Herman W. Connersville
Daley, Edward H. Oldenburg

FLOYD COUNTY

Engleman, Harry K. Georgetown

New Albany

Baker, Avey M. 811 E. Spring
Baxter, Jas. W., Jr. 1201 E. Spring
Baxter, Saml. M. 1201 E. Spring
Best, Maurice M. Lilly Lane
Briscoe, C. E. 1413 E. Spring
Brown, Kenneth H. 410 E. Spring
Byrn, Howard W. 416 Elsy Bldg.
Cannon, Daniel H. Elsy Bldg.
Cohn, Phillip Silvercrest Hosp.
Davis, D. F. (H) 2403 E. Market
Davis, Parvin M. 601 E. Spring
Day, George H. 1252 Vincennes
Edwards, William F.

Floyd County Bank Bldg.
Garner, Wm. H. 919 E. Spring
Gentile, John P. 1313 E. Spring
Hauss, A. P. 212 Elsy Bldg.
Hofferkamp, A. G. Silvercrest San.
LaFollette, Robt. E. 500 Spring
McCullough, J. Y. 624 E. Spring
Murphy, Edgar W. 1824 State
Pace, Jerome V. Silvercrest San.
Paris, John M. 150 E. Spring
Pierson, Percy R.

203 Liberty State Bank Bldg.
Polhemus, G. I. 1610 E. Spring
Robertson, A. N. 820 E. Spring
Sloan, Herbert 1207 E. Spring
Strange, Martin B. 1228 Vincennes
Streepey, J. I. 1102 E. Spring
Tyler, Frank T. 420 Vincennes
Voyles, Harry E. 213 Elsy Bldg.
Weaver, Wm. W. 1104 E. Spring
Winsteadley, W. C. (H)

815 Vincennes
Wolfe, Nelson 908 E. Spring
Hewlett, Thos. H. Oncologic Hosp.
Philadelphia, Pa.

FRANKLIN COUNTY

(See Fayette-Franklin)

FOUNTAIN-WARREN COUNTIES

Fisher, John E. Attica
Freed, Carl A. Attica
Freed, James C. Attica
Kerr, Alvin R. Attica
Maris, Lee J. Attica
Aldridge, James W. Covington
Johnson, Earl E. Covington
Stephens, Lowell R. Covington
Ratcliff, A. Lonzo (H) Kingman
Smith, Byron J. Kingman
Himebaugh, G. J. Veedersburg
McCord, Carl B. Veedersburg
Rusk, Hubert M. Wallace
Nelson, Carl A. West Lebanon
Crain, James W. Williamsport
Schmiedicke, P. H. Williamsport

FULTON COUNTY

Herrick, Charles L. Akron
Miller, Virgil Akron
Dielman, Franklin C. Fulton
Kelsey, Lawrence E. Kewanna
Kraning, Kenneth K. Kewanna
Glackman, John C. Rochester
Herendeen, Elbie V. Rochester
King, Milo O. Rochester
Meek, Loring (H) Rochester
Richardson, Chas. L. Rochester
Rowe, Howard H. Rochester
Stinson, Arthur E. Rochester
Stinson, Dean K. Rochester

GIBSON COUNTY

Geick, Raymond G. Fort Branch
Klein, Hilbert P. Fort Branch
Marchand, Austin F. Haubstadt
Marchand, Edwin V. Haubstadt
Pettijean, Harold G. Haubstadt
Arthur, Hamilton M. (H) Hazelton
Ropp, Eldon R. Oakland City
Turner, Maurice Oakland City
Wood, Russell W. Oakland City
Wood, Wm. B. Oakland City
Montgomery James R. Owensville
Alexander, Harry H. Princeton
Brazelton, Osborne T. Princeton
Carpentier, Harry F. Princeton
Folck, John K. Princeton
Graves, Orville M. Princeton
Hollingsworth, M. P. (H) Princeton
McCarty, Virgil Princeton
McElroy, Robert S. Princeton
Miller, Charles A. (H) Princeton
Morris, William F. Princeton
Peck, James F. Princeton
Rhodes, Amos H. Princeton
Strickland, Karl S. Princeton
Weitzel, Roland Princeton

GRANT COUNTY

Belshaw, George Fairmount
Henley, Glenn Fairmount
Holliday, L. D. Fairmount
Seale, Joseph P. Fairmount
Garrison, Leon J. Gas City
Koontz, William A. Gas City
Baskett, Russell J. Jonesboro

Marion

Abell, Chas. F. 321 Natl. Bk. Bldg.
Ayres, Wendell W. 302 Glass Blk.
Bloom, Asa W. 724 W. Third
Boyer, Grace M. 313 Iroquois Bldg.
Braunlin, Robert F.
718 Marion Nat. Bank Bldg.
Braunlin, William H.
718 Marion Nat. Bank Bldg.
Brown, Robert M.
522 Marion Nat. Bank Bldg.
Bryan, Franklin A. Veterans Hosp.
Burge, A. D. 204 Odd Fellows Bldg.
Daniels, Erle O.
708 Marion Nat. Bank Bldg.
Daniels, Geo. R. 324 Glass Blk.
Davis, Joseph B.
516 Marion Nat. Bank Bldg.
Davis, Merrill S.
516 Marion Nat. Bank Bldg.
Diamond, Leo L.
612 Marion Nat. Bank Bldg.
Eisaman, Cecil 1525 E. 35th St.
Eshleman, L. H. (H) 2927 S. Wash.
Fisher, Henry 1502 S. Wash.
Fisher, Pierre J. 2928 S. Wash.
Ganz, Max 930 S. Adams

Ginsberg, S. T. Veterans Hosp.
Huff, Asher D. 310 Glass Blk.
Hummel, Russel M.

317 Marion Nat. Bank Bldg.
Lavengood, R. W. 511 Glass Blk.
Long, Max R. 803 S. Boots
McIlwain, Eleanor E. 107 E. 31st
McIlwain, Robt. E. 107 E. 31st
Miller, H. Allison 321 Glass Blk.
Powell, J. Paxton 309 Glass Blk.
Powell, Nettie B. (H) 615 Whites
Renbarger, L. L. 1531 W. Second
Rhorer, John G. 201 S. D St.
Sandy, Wm. A. Veterans Hosp.
Simmons, Fredk. H.

5061 Glass Blk.
Skomp, C. E. Marion Gen. Hosp.
Sullenger, A. A. Marion Gen. Hosp.
Warren, Carroll B. 408 Glass Blk.
Weinberg, Samuel 318 Glass Blk.
Weinstein, Louis Veterans Hosp.
Williams, C. L. Veterans Hosp.
Young, Robt. G. 2927 S. Wash.
King, Peter C. Swayzee
Taylor, Everett C. Upland
Rifner, E. S. Van Buren
List, Harold E. Naval Air Sta.,
Key West, Fla.

GREENE COUNTY

Graf, Jerome A. Bloomfield
Mount, Mathias S. Bloomfield
Turner, Harold B. Bloomfield
Turner, Jack J. Bloomfield
Van Sandt, Frank A. Bloomfield
Porter, Carl M. Jasonville
Rotman, Harry G. Jasonville
Rotman, Sam I. Jasonville
Bailey, Edwin B. Linton
Broshears, Kenneth Linton
Craft, William F. Linton
Porter, George C. Linton
Raney, Ben B. Linton
Tomak, Milton E. Linton
Woner, John W. Linton
Manzies, Michael W. Lyons
Simons, James S. (H) Lyons
Hamilton, M. Luther Newberry
Fender, Asa H. Worthington
Moses, George E. Worthington
Moses, Robert E. Worthington

HAMILTON COUNTY

Hicks, Joseph (H) Arcadia
Rodenbeck, Frank Arcadia
McDaniel, Franklin P. Atlanta
Campbell, Sam W. Carmel
Donahue, Claude M. Carmel
Havens, Oscar Cicero
Tomlinson, Carlton H. (H) Cicero
Ambrose, Jesse C. Noblesville
Harris, Robert F. Noblesville
Hash, John S. Noblesville
Hooke, Samuel W. Noblesville
Kraft, Haldon C. Noblesville
Russell, O. Raymond Noblesville
Shanks, Ray Noblesville
Shonk, Harold W. Noblesville
Southard, Carl B. Noblesville
Thayer, Jos. O. R. R. 1, Noblesville
Griffith, James W. Sheridan
Newby, Alonzo C. Sheridan
Newby, Eugene Sheridan
Reck, John L. Sheridan
Young, Edward M. (H) Sheridan
Connoy, Andrew F. Westfield
Connoy, Leo F. Westfield

HANCOCK COUNTY

Scott, Robert O. Charlottesville
 Ferrell, Jesse E. Fortville
 Ferrell, Mars B. Fortville
 Navin, Hugh K. Fortville
 Allen, Joseph L. Greenfield
 Endicott, Wayne Greenfield
 Gibbs, Charles M. (H) Greenfield
 Gill, Dee D. Greenfield
 Hawk, Edgar Greenfield
 Heller, Oscar S. (H) Greenfield
 Kinneman, Robert E. Greenfield
 Rariden, Lawrence B. Greenfield
 Woods, James R., Jr. Greenfield
 Larrabee, William H. (H)

New Palestine

Pierson, Thos. A. New Palestine
 Kuhn, Robert W. Wilkinson
 Titus, Charles R. (H) Wilkinson
 Godwin, J. David 1050 Garnett St.,
 San Diego, Calif.

HARRISON COUNTY

Amy, William E. Corydon
 Clunie, William Corydon
 Dillman, Carl E. Corydon
 Gwinn, John L. Corydon
 Yochem, August S. Corydon
 Baker, Guy D. Crandall
 Bierly, Fred Elizabeth
 Mathys, Alfred Mauckport
 Johnson, J. M. Palmyra
 Glenn, Lafayette Ramsey
 Applegate, Frederick M.

Monahans, Texas

HENDRICKS COUNTY

Foltz, Lloyd E. Brownsburg
 Scudder, Arthur N. Brownsburg
 Tyner, Harlan H. Clayton
 Ellett, John, Jr. Coatesville
 Frantz, Mount E. Danville
 Gibbs, Joseph W. Danville
 Huckleberry, Carl D. Danville
 Price, Ernest H. Danville
 Terry, Lloyd Danville
 Ellis, Lyman H. Lizton
 Wiseheart, Oscar H. North Salem
 Scamahorn, Malcolm O. Pittsboro
 Scamahorn, Oscar T. Pittsboro
 Aiken, Milo M. Plainfield
 Johnston, Alan Plainfield
 Stafford, James C. Plainfield
 Stafford, William C. Plainfield
 Morgan, Hallie I., State Dept. of
 Health, Charleston, W. Va.

HENRY COUNTY

Call, Earle B. Knightstown
 Dreyer, Ralph W. Knightstown
 Shively, John L. Knightstown
 Walker, Jack Knightstown
 Scheetz, Marion R. Lewisville
 Arford, Roxford D. Middletown
 Dragoo, Farrol Middletown
 Hammer, Jay W. Middletown
 Stamper, Joseph Middletown
 Stauffer, George E. Mooreland
 Marshall, Lloyd C. Mt. Summit
 Albright, Victor F. New Castle
 Amos, Robert L. New Castle
 Bitler, Clyde C. New Castle
 Blaize, Joshua A. New Castle
 Bledsoe, James G. New Castle
 Canaday, Clifford E. New Castle
 Coats, Edwin A. New Castle
 Heilman, William C. New Castle

Hill, Kenneth New Castle
 Itermann, George E. New Castle
 Kennedy, Walter U. New Castle
 Life, Homer L. New Castle
 McDonald, Frank C. New Castle
 McElroy, James S. New Castle
 Smith, Robert A. New Castle
 Stout, Walter M. New Castle
 Thorne, Charles E. New Castle
 Tully, John A. New Castle
 Van Nuys, W. C. New Castle
 Wiggins, Dulania S. (H)
 Wiggins, George New Castle
 Robertson, William S. Spiceland
 Freeman, Joseph W., Bldg. No. 318,
 Ft. Logan, Denver, Colo.

HOWARD COUNTY

Denton, Larkin D. Greentown
 Shoup, Homer B. Greentown
 Kokomo
 Adams, Charles J.
 618 Armstrong-Landon Bldg.
 Boughman, Joe D.
 322 Armstrong-Landon Bldg.
 Bowers, Copeland C.
 210 W. Mulberry St.
 Bowers, Garvey B.
 210 W. Mulberry St.
 Bowers, John A.
 210 W. Mulberry St.
 Bruegge, Theodore J.
 630 Armstrong Landon Bldg.
 Clarke, Elton R. 400½ N. Main St.
 Conley, Thomas M.
 520 Union Bank Bldg.
 Craig, Reuben A.
 608 Armstrong-Landon Bldg.
 Cuthbert, Frederick S.
 211 E. Jefferson St.
 Ferry, Paul W.
 406 Union Bank Bldg.
 Good, Richard P.
 308 Armstrong-Landon Bldg.
 Harrison, William H. (H)
 318½ N. Main St.
 Harvey, Bennett B.
 St. Joseph Memorial Hospital
 Hutto, William H.
 408 Armstrong-Landon Bldg.
 Jewell, George M.
 508 Armstrong-Landon Bldg.
 Knepple, LaMarr R. (H)
 325½ N. Main St.
 Kratzer, Eugene F.
 320 W. Walnut St.
 Lung, Bruce D.
 410 Union Bank Bldg.
 McIndoo, Ralph E.
 304 W. Walnut St.
 Martin, William J.
 113½ W. Mulberry St.
 Meiner, Joseph A. 911 S. Main St.
 Morrison, David A.
 504 Union Bank Bldg.
 Morrison, William R.
 504 Union Bank Bldg.
 Murray, Ernest C.
 207 E. Mulberry St.
 Murray, Frederick N.
 301 W. Markland St.
 Paris, Durward W.
 614 Armstrong-Landon Bldg.
 Phares, Robert W.
 905 W. Mulberry St.
 Ramey, John W. 107½ S. Union St.

Rhorer, Herbert M.
 210 W. Mulberry St.
 Schuler, Russell P.
 200½ N. Main St.
 Schwartz, Frederick C.
 518 Armstrong-Landon Bldg.
 Scott, Russell F. Union Bank Bldg.
 Shenk, Earl M. 208½ N. Main St.
 Smith, Gloster J.
 105½ E. Sycamore St.
 Sorenson, Raymond
 1526 W. Sycamore St.
 Spangler, Jesse S. 215 E. Taylor St.
 Evans, Robert M. Russiaville
 Wilson, Fred M., 904 W.
 Adams St., Chicago 7, Ill.

HUNTINGTON COUNTY

Omstead, T. W. Andrews
 Brubaker, Harold S. Huntington
 Casey, Stanley M. Huntington
 Erehart, Mark G. Huntington
 Eviston, John B. Huntington
 Galbreath, Russell S. Huntington
 Gray, Paul M. Huntington
 Grayston, Fred W. (H) Huntington
 Grayston, Wallace S. Huntington
 James, Thomas, Jr. Huntington
 Johnston, Robert G. Huntington
 Marks, Howard H. Huntington
 Meiser, Robert D. Huntington
 Mitman, Floyd B. Huntington
 Nie, Grover M. Huntington
 Ware, J. Roger Huntington
 Wimmer, George G. Huntington
 Woods, Halden C. Markle
 Bigelow, Oliver P. Roanoke
 Bennett, J. B. Warren
 Black, Claude S. Warren
 Bonifield, Harold F. Warren
 Smith, Lucian Warren

JACKSON COUNTY

Cummings, David J. Brownstown
 Gillespie, Garland R. Brownstown
 Shields, Jack E. Brownstown
 Adair, William K. Crothersville
 Bard, Frank B. Crothersville
 Conner, Thos. E. (H) Freetown
 Black, Joe M. Seymour
 Day, William D. C. Seymour
 Elsner, Lawrence W. Seymour
 Gillespie, Charles E. Seymour
 Graessle, Harold P. Seymour
 Kamman, Geo. H. (H) Seymour
 Martin, Guy Seymour
 Miller, Harold E. Seymour
 Osterman, Louis H. Seymour
 Ripley, John W. Seymour
 Shortridge, Wilbur H. Seymour
 Wright, Elmer D. Seymour
 Abel, Virgil Vallonia

JASPER-NEWTON COUNTIES

Pippenger, Wayne G. Brook
 Ockermann, Kenneth R. . . . DeMotte
 McClellan, John B. Goodland
 Openshaw, James F. Goodland
 Glick, Orval E. Kentland
 Mathews, Wilbur C. Kentland
 VanKirk, George H. Kentland
 Yegerlehner, Roscoe S. . . . Kentland
 Harrison, Glenn D. Morocco
 Zeiger, Irvin Morocco
 Schantz, Richard Remington
 Sink, Frank G. Remington

JASPER-NEWTON COUNTIES (Continued)

Beaver, Ernest Rensselaer
English, Harry E. Rensselaer
Johnson, Cecil E. Rensselaer
Kresler, Leon Rensselaer
O'Neill, Martin Rensselaer
Gwin, Merle D., 2111 Regatto Ave.,
Sun Set Island, No. 4, Miami
Beach, Fla.
Dick, Jack . . . R. R. 21, New Albany

JAY COUNTY

Garber, Erwin C. Dunkirk
Hall, Emory H. Dunkirk
Heller, Nelson L. R. Dunkirk
Pruitt, Edward Dunkirk
Hiestand, Harley J. Pennville
Badders, Ara C. Portland
Cring, George V. Portland
Dulin, Basil Portland
Engle, John M. Portland
Hammond, Stanley M. Portland
Hennessee, Philip C. Portland
Keeling, Forrest E. Portland
Lyon, Florence Portland
Moran, Mark M. Portland
Morrison, George G. Portland
Nixon, Jesse E. Portland
Schwartz, Wm. D. (H) Portland
Spahr, Donald E. Portland
Streib, Homer F. Portland
Walker, Wm. H. (H) Portland
Lansford, John Redkey
Kidder, John J. (H) Salamonia

JEFFERSON COUNTY

Henning, Carl Hanover
Madison

Beetem, Luther F. 425 W. Main St.
Cook, Elbert C. Madison
Denny, Fred C. Odd Fellows Bldg.
Hamilton, Guy W. Clifty Inn
Jolly, Lewis E. Madison
Kemp, M. Walter

Madison State Hospital
May, George A. 426 E. Main St.
Modisett, Jackson W.

Odd Fellows Bldg.
Modisett, Marcella S. Madison
Moore, Martha

Madison State Hospital
Petway, Allen P. 426 E. Main St.
Prenatt, Francis

Madison State Hospital
Sharman, E. J. 610 E. Second St.
Totten, Evan C. 415 W. Second St.
Turner, Anna L. 104 E. Third St.
Turner, Oscar A. 104 E. Third St.
Whitsitt, Schulyer A. (H)
718 W. Main St.

JENNINGS COUNTY

Daubenheyer, Miles Frederick
Butlerville
Scodel, Benson Butlerville
Robertson, David W. (H) Deputy
Green, John H. North Vernon
Grossman, Wm. L. North Vernon
Matthews, Dennis W. North Vernon
Steram, William H. (H) North Vernon
Thayer, Benet W. North Vernon

JOHNSON COUNTY

Lutes, D. L. Edinburg
Michaels, Joseph F. Edinburg
Deppe, Charles F. Franklin
Eaton, Lyman D. Franklin
Jones, Charles A. Franklin
Murphy, George M. Franklin
Murphy, Harry E. Franklin
Portteus, Walter L. Franklin
Province, Oran A. Franklin
Province, William D. Franklin
Records, Arthur W. Franklin
Wilson, Russell C. Franklin
Barnes, Helen Beall Greenwood
Brown, George E. Greenwood
Sheek, Kenneth I. Greenwood
Tiley, George A. Greenwood
Woodcock, Charles E. Greenwood
Machledt, John H. Whiteland

KNOX COUNTY

Byrne, Robert J. Bicknell
Donham, William L. Bicknell
Fox, Richard H. Bicknell
Little, William J. Bicknell
Meade, Walter W. Bicknell
Wilson, Guy H. Bicknell
Scudder, John A. Edwardsport
Raper, Geo. T. Freelandville
Bland, Curtis Oaktown
Hodges, William A. Oaktown
Springstun, George H. Oaktown
Johnson, Ernest N. Sandborn
Pahmeier, John W. Sandborn

Vincennes

Albrecht, Joseph R.
200 Harrison Bank Bldg.
Anderson, Richard M.
301 LaPlante Bldg.
Arbogast, Paul B. 915 Main St.
Bailey, W. A. (H) 516 Busseron St.
Beckes, Ellsworth W.
603 Busseron St.
Beckes, N. E. (H) 414 Broadway
Boyd, Claudius L. 114 N. 4th St.
Chattin, Herbert O. 729 Main St.
Coffel, Melvin H.
424 LaPlante Bldg.
Curtner, Myron L. 222 N. 6th St.
Edwards, Edward T., Jr.
1232 N. 11th St.
Ewing, Nathaniel D. 14 N. 3rd St.
Fox, Maurice S., 223-30
American Natl. Bank Bldg.
Gilmore, Louis L. 430 N. 2nd St.
Green, Carl L. 1004 Main St.
Hoffman, Doris 324 Vigo St.
Humphreys, Joe E. 217 N. 3rd St.
Johnson, Morris H. C. 9 N. 5th St.
McCormick, Hubert D.
325 LaPlante Bldg.
McDowell, Mordecai M.
223 American Bank Bldg.
McMahan, Virgil C.
410 LaPlante Bldg.
Meyer, Raymond C.
Hillcrest Hospital
Moore, Robert G. 21 N. 3rd St.
Nance, William K. 324 Vigo St.
Reilly, James F. 418½ Main St.
Richards, D. H. (H)
215 American Natl Bank Bldg.
Schulze, William
223 American Bank Bldg.

Shaffer, Kenneth L.
404 LaPlante Bldg.
Smith, Samuel J.
301 LaPlante Bldg.
Spencer, Frederic
421 LaPlante Bldg.
Pierce, Gene S. Wheatland
Knapp, A. B. (H)
8073 W. Main St., Belleville, Ill.

KOSCIUSKO COUNTY

Leasure, Kenneth Etna Green
Thomas, Charles E. Leesburg
Urschel, Dan Mentone
Hursey, Virgil G. Milford
Stalter, G. Wm. N. Webster
Herring, George N. Pierceton
Kuhn, Benjamin F. (H) Pierceton
Schuldt, T. S. Pierceton
King, James R. Silver Lake
Clark, Fred Syracuse
Craig, Robert A. Syracuse
Fosbrink, E. L. Syracuse
Dubois, Charles C. Warsaw
Haymond, George M. Warsaw
Hillery, John L. Warsaw
Leininger, Hilbert A. P. Warsaw
Richer, Orville H. Warsaw
Schlemmer, George H. Warsaw
Thomas, Everett W. Warsaw
Kress, Geo. L., Veterans
Administration, Temple, Texas

LAGRANGE COUNTY

Wade, Alfred A. Howe
Benedict, Charles D. LaGrange
Flannigan, Harley F. LaGrange
Schulz, Clarence H. LaGrange
Robertson, Wm. Shipshewana
Hildebrand, William O. Topeka
Lehman, Kenneth M. Topeka

LAKE COUNTY

King, Robert W. Cedar Lake
Spindler, Robert D. Cedar Lake
Crown Point
Becker, Philip H.
Lake County T. B. Sanitarium
Birdzell, John P. 124 N. Main St.
Gray, Daniel E. 235 S. Main St.
Horst, William N. Crown Point
Klaus, Julius N. 224 S. Court St.
Iddings, John W. 124 N. Main St.
Merchant, Raymond

269 S. Maxwell
Monroe, F. Bruce. Crown Point
Seyler, Anna G.

Lake Co. T. B. Sanitarium
Steele, Everett B. 124 N. Main St.
Troutwine, Wm. 224 S. Court St.
Weis, William D. (H) Court House
Adler, Edmund R. Dyer

East Chicago

Arnold, Marion. 4614 Indianapolis
Beam, Vernon B. DuPont Co.
Beilke, Clifford A. 815 W. Chicago
Benchick, Frank A.
4712 Magoun Ave.
Benedek, Tibor 3406 Guthrie St.
Bergan, Jos. A. 3406 Guthrie
Bonaventura, Angelo P.
3701 Main St.
Boyd, Chas. S. 4739 Melville Ave.
Boys, Fay F. 722 W. Chicago Ave.
Brauer, A. A. 3528 Main St.
Braun, Benjamin D.
St. Catherine's Hospital

LAKE COUNTY

(East Chicago—Continued)

- Broomes, Edw. L. 3924 Deal St.
 Callahan, Richard H. 3502 Main St.
 Campagna, Ettro A. 3406 Guthrie
 Carleton, Edward H.
 Inland Steel Co.
 Cole, Arthur V. 3406 Guthrie St.
 Cotter, Edward R.
 720 W. Chicago Ave.
 Dainko, Alfred J.
 823 W. Chicago Ave.
 Ernst, Helmuth C. W.
 720 W. Chicago Ave.
 Fleischer, Jacob C. 3406 Guthrie
 Govorchin, Alexander
 724 W. Chicago Ave.
 Grosso, William G.
 722 W. Chicago Ave.
 Gustaitis, John W.
 St. Catherine's Hospital
 Hamilton, Robert C.
 2602 E. 140th Place
 Hayes, Jesse D. 2302 Broadway
 Irish, Wilbur 806 W. Chicago Ave.
 Johns, David R.
 724 W. Chicago Ave.
 Komoroske, John E.
 723 E. Chicago Ave.
 Levin, Eli 3700 Main St.
 McGuire, Desmond F.
 3429 Michigan Ave.
 Marks, Ora L. 815 W. Chicago Ave.
 Mervis, F. H. 3414 Michigan
 Nakadate, Katsumi J.
 815 W. Chicago Ave.
 Niblick, James S. 3406 Guthrie
 Nicosia, John B. 3701 Main St.
 O'Connor, James J. 3701 Main St.
 Payne, Arthur C. 2020 Broadway
 Petronella, Samuel J.
 4614 Indianapolis Blvd.
 Ramker, Daniel T.
 3406 Guthrie Ave.
 Shapiro, Joseph 3700 Main St.
 Shulruff, Harry I. 3701 Main St.
 Smith, Louis D.
 St. Catherine's Hospital
 Teegarden, Joseph A., Jr.
 3336 Michigan Ave.
 Teegarden, Joseph A.
 3336 Michigan Ave.
 Trepagnier, Francis B.
 3616 Main St.
 Vore, Hugh A. 4231 Magoun Ave.
 Weiland, Albert S. 3406 Guthrie St.
 Zallen, Stanley G. 720 W. Chicago
 Zivich, John 3701 Main St.
 Gary
 Almquist, Carl O. 504 Broadway
 Anthoulis, Geo. D. 1206 Broadway
 Baitinger, Herbert M.
 504 Broadway
 Behn, Walter M. 738 Broadway St.
 Bendler, Carl H. 738 Broadway
 Bills, Robert N. 504 Broadway
 Boardman, Carl 504 Broadway
 Borak, Walter J.
 36 West 5th Ave.
 Brady, Samuel G. 100 E. 7th Ave.
 Brandman, Harry 738 Broadway
 Brink, Calvin C. 504 Broadway
 Brown, David B. 504 Broadway
 Brown, Leo R. 3855 Broadway
 Bullard, Mattie J. 524 Garfield St.
 Burcham, James B. 738 Broadway
 Carbone, Joseph A. 504 Broadway
 Carmody, Raymond F.
 504 Broadway
 Chevigny, Julius J. 504 Broadway
 Cooper, Leo K. 504 Broadway
 Cofferman, Vernon L.
 3811 Washington St.
 Crossland, Steward H.
 Methodist Hospital
 Danieleski, Ladislaus J.
 738 Broadway
 Darling, Dorothy 1600 W. 6th Ave.
 DeLong, Charles A. (H)
 583 Broadway
 Dian, August J. 729 Broadway
 Dian, Julia 729 Broadway
 Dierolf, Edward J. 504 Broadway
 Donchess, Joseph C. 215 Broadway
 Doty, James R. 504 Broadway
 Duncan, John S. 2165 W. 11th St.
 Elliott, Ralph A. 504 Broadway
 English, Hubert M. 673 Broadway
 Fischer, Burnell 1070 Warren Ave.
 Galante, Vincent J. Mercy Hospital
 Gannon, George W. 602 Broadway
 Goad, Lloyd A. 765 Broadway
 Goldberg, Harold B. 515 Broadway
 Goldstone, Adolph 757 Broadway
 Goldstone, Joseph 757 Broadway
 Goldstone, S. R. 757 Broadway
 Gorton, Mary L. 400 Broadway
 Grant, Benjamin 1706 Broadway
 Gutierrez, Frank A. 504 Broadway
 Harris, Donald N. 4375 Jackson St.
 Hinkson, Geo. D. 1606 Broadway
 Hodurski, Zigfield 4319 Broadway
 Jannasch, M. C. 738 Broadway
 Johnson, Lonnie B. 2141 Adams St.
 Kahan, Harry L. 738 Broadway
 Kendrick, Frank J. 504 Broadway
 Knoy, Norris J. 772 Van Buren St.
 Kobrak, Heinrich F. G. 336 Grant
 Kobrin, Meyer W. 729 Broadway
 Kolettis, George J. 860 Broadway
 Kopcha, Joseph E. 504 Broadway
 Korn, Jerome M. 742 Broadway
 Kron, R. Vincent 3538 Central
 Lebioda, Henry S. 3886 Broadway
 Lorenty, Thaddeus B.
 738 Broadway
 Lovell, Martin H. 1606 Broadway
 Lutz, Georgianna 504 Broadway
 McMichael, F. J. 504 Broadway
 Majsterek, Stanley L.
 1902 W. 11th Ave.
 Marcus, Morris C. 738 Broadway
 Mather, J. Winford
 3543 Central, East Gary
 May, Richard M. 583 Broadway
 Minczewski, Richard C.
 504 Broadway
 Molengraft, Cornelius J.
 527 Broadway
 Moore, Edwin G. 1606 Broadway
 Morris, Hyman 17 W. 8th Ave.
 Moswin, Jack A. 790 Broadway
 Nelson, Walfred A. 559 S. Lake St.
 Nesbit, Otis B. (H) 444 Jackson St.
 Neuwelt, Frank 504 Broadway
 Ornelas, Jos. P. 607 Broadway
 Palmer, Russell H.
 2006 W. 4th Place
 Parker, Harry C. 673 Broadway
 Parker, John T. 673 Broadway
 Parratt, Louis W. 100 E. 7th Ave.
 Puryear, James O. 1606 Broadway
 Reynolds, James S. 504 Broadway
 Richter, Samuel 738 Broadway
 Robinson, Walter K. 504 Broadway
 Rosenbloom, Philip J.
 504 Broadway
 Rubin, Milton R. 504 Broadway
 Rubin, Simon S. 504 Broadway
 Ryan, Hubert J. 504 Broadway
 Sagel, Jacob 504 Broadway
 Sala, Joseph J. 504 Broadway
 Sala, Walter R. 504 Broadway
 Schaible, Ernest L. 738 Broadway
 Senese, Thos. J. 504 Broadway
 Shellhouse, Michael
 3811 Washington St.
 Skeen, Earl D. 504 Broadway
 Slama, Earl D. 3624 Buchanan
 Spellman, F. A. 564 S. Lake St.
 Sponder, Joseph 1512 Broadway
 Stimson, Harry R. 504 Broadway
 Stoycoff, Christo M. 844 Broadway
 Templin, David B. 504 Broadway
 Trinosky, Donald L. 504 Broadway
 Verplank, Grover L. 527 Broadway
 Vye, James P. 607 Broadway
 Weiskopf, Henry S. 504 Broadway
 Wharton, Russell O. 673 Broadway
 White, W. J. (H) 790 Broadway
 Wicks, Orlando C. (H)
 560 Van Buren
 Williams, Alexander S.
 504 W. 25th Ave.
 Wimmer, Robert N. 9 W. 6th St.
 Yarrington, Charles W.
 607 Broadway
 Yocum, Paul S. 738 Broadway
 Yocum, Wm. S. 583 Broadway
 Young, George M. 3776 Broadway
 Hazinski, R. T. Griffith
 Malmstone, Francis A. Griffith
 Siekierski, Joseph M. Griffith
 Hammond
 Allegetti, Michael L.
 5404 Hohman Ave.
 Arbeiter, Herbert I.
 5231 Hohman Ave.
 Arrowsmith, James L.
 5231 Hohman Ave.
 Becomovich, Robt. 839 169th St.
 Bethea, Dennis A. 1021 Fields St.
 Bohin, John T. 5305 Hohman Ave.
 Brown, Stanley L.
 6550 Hohman Ave.
 Carlo, Joseph F.
 5305 Hohman Ave.
 Chidlaw, B. W. 5141 Hohman Ave.
 Clancy, James F.
 5231 Hohman Ave.
 Cook, George M.
 5231 Hohman Ave.
 Dassel, Paul Milton
 6744 Hohman Ave.
 Davis, Alice L. 5116 Hohman Ave.
 Detrick, Herbert W.
 5231 Hohman Ave.
 Eggers, Ernest L.
 5141 Hohman Ave.
 Eggers, Henry W.
 5231 Hohman Ave.
 Egnatz, Nicholas 522 State St.
 Elledge, Ray 5231 Hohman Ave.
 Friedman, Isadore E.
 5248 Hohman Ave.
 Gevirtz, Milton B.
 5246 Hohman Ave.
 Hack, Edmund C.
 5219 Hohman Ave.
 Handelman, E. 5231 Hohman Ave.

LAKE COUNTY (Hammond—Continued)

Hansen, Arthur H.
5252 Hohman Ave.
Hickman, A. L. 5248 Hohman Ave.
Hofmann, Andrew . . . 408 State St.
Hopkins, J. R. . . . 5217 Hohman Ave.
Howard, William H.
5231 Hohman Ave.
Husted, Robert G.
5248 Hohman Ave.
Jones, Eli S. . . . 5231 Hohman Ave.
Kenney, Francis D.
5231 Hohman Ave.
Kolanko, Leon A.
5435 Hohman Ave.
Koransky, David S.
5231 Hohman Ave.
Kretsch, Russell W.
5434 Hohman Ave.
Kuhn, Hedwig S. . . . 112 Rimbach St.
Kuhn, Hugh A. . . . 112 Rimbach St.
Larrabee, James F.
5245 Hohman Ave.
McVey, Clarence A.
5231 Hohman Ave.
Marcus, Emanuel . . . 6745 Indi Illi St.
Marks, Salvo 409 Yale Bldg.
Matthews, Charles B. (H)
5252 Hohman Ave.
Modjeski, Joseph R.
5451 1/2 Hohman Ave.
Modjeski, Raymond J.
5231 Hohman Ave.
Morrison Lindsey (H)
109 Rimbach St.
Musacchio, Frederick A.
330 City Hall
Neal, Leonard W.
5252 Hohman Ave.
Nelson, Richard B.
5618 Calumet Ave.
Nichols, William E. (H)
15 Warren St.
Nodinger, Louis 540 165th St.
Ostrowski, R. O.
5434 Hohman Ave.
Panares, Solomon V.
5434 Hohman Ave.
Paul, William Thomas F.
5434 Hohman Ave.
Peck, Edward A. . . . 422 Conkey St.
Pilot, Jean 5231 Hohman Ave.
Premuda, F. F. 6727 Kennedy Ave.
Rauschenbach, Charles W.
5245 Hohman Ave.
Rawlins, Carolyn M. . . 614 173rd St.
Remich, Antone C. 137 Rimbach St.
Rendel, Donald T.
5231 Hohman Ave.
Rhind, A. W. . . . 5145 Hohman Ave.
Rosevear, Henry S.
5231 Hohman Ave.
Row, Perrie Q. . . . 5231 Hohman Ave.
Rudolph, Franklin G.
5231 Hohman Ave.
Schlesinger, Daniel J.
6010 Columbia
Schlesinger, Jacob
6010 Columbia Ave.
Shanklin, E. M. 5141 Hohman Ave.
Skrentny, Stanley H.
5231 Hohman Ave.
Sosson, Edward 112 Rimbach
Stern, Samuel L.
5142 Hohman Ave.

Tilka, Edward . . . 5231 Hohman Ave.
Zeman, Theodore C.
112 W. Rimbach St.
Dupes, Lowell E. Hobart
Markle, Joseph G. Hobart
Pike, Warren H. Hobart
Bergen, Paul M. Lowell
Storer, W. R. Hobart
Combs, Loyal William Jr. . . Lowell
Davis, Neal Lowell
Mirro, John A. Lowell
Tennant, M. M. . . . 8237 Forest Ave.,
Munster
Teplinsky, Louis L. Munster
Whiting
Bopp, David W.
1902 Indianapolis Blvd.
Ferry, John
1902 Indianapolis Blvd.
Frankowski, Clementine E.
1907 New York Ave.
Jones, Clifford M.
1902 Indianapolis Blvd.
Kudele, Louis T. . . . 1321 119th St.
LaFollette, Forrest R.
1900 Indianapolis Blvd.
Marshall, Milliard R.
1900 Indianapolis Blvd.
McCarthy, Jeremiah A.
1341 E. 119th St.
Rudser, Donald H.
1902 Indianapolis Blvd.
Silvian, Harry A. . . . 1400 119th St.
Smith, Theodore J.
1902 Indianapolis Blvd.
Stecy, Peter
1902 Indianapolis Blvd.
Thegze, G. A. 1344 119th St.
Troy, Jack M.
1900 Indianapolis Blvd.
Weinberg, B. A. . . . 1348 119th St.
Diamondstein, Joseph
796 State Line St.,
Calumet City, Ill.
Forster, Nelsen K.
1339 N. Capri Drive
Pacific Palisades, Calif.
Harris, Bryum W.
Box 414, Lake Wales, Florida
Holmes, George W.
340 W. Barry Ave., Chicago, Ill.
Josif, Lazar 419 Orilla,
Santa Barbara, Calif.
Pettibone, Claude R.
22 University Dr.,
East Lansing, Mich.
Tyrrell, Thomas C.
704 Wentworth Ave.,
Calumet City, Ill.
Vracin, Daniel J.
10727 S. Paramount Blvd.,
Downey, Calif.

LaPORTE COUNTY

Oak, David Jr. Hanna
Oak, David D. LaCrosse
LaPorte
Cartwright, Jack D.
806 Madison St.
Elshout, Clem H. 1002 Indiana Ave.
Fargher, Robert A.
811 Jefferson Ave.
Farnsworth, Samuel A.
702 Lincoln Way
Fischer, Carlton N.
1001 Maple Ave.

Jones, John C. Monroe Apts.
Jones, Robert B.
808 Michigan Avenue
Kelly, Jon N. . . . 704 Jefferson Ave.
Kelsey, Robert M. . . 702 Maple Ave.
Kepler, Robert W. . . 708 Harrison St.
Kistler, James J. . . . 911 Maple Ave.
Larson, G. O. 809 Jefferson St.
Linn, Elbert E. . . . 809 Jefferson St.
Martin, William B.
812 Michigan Ave.
Morgan, Samuel P.
810 Michigan Ave.
Muhleman, C. E. 901 Indiana Ave.
Przednowek, Adolph C.
909 Madison St.
Ross, Wilbur W. . . . P.O. Box 102
Simon, Arthur R. . . . 806 Maple Ave.
Von Asch, George . . . 912 Monroe St.
Wilcox, Robert F. . . 808 Maple Ave.
Michigan City
Armstrong, Thomas D.
113 E. Ninth St.
Baker, Warren . . . 427 Warren Bldg.
Bankoff, Milton L. 123 E. Fifth St.
Bernoske, Daniel G. . . 731 Pine St.
Brooks, Harry L. . . . 123 E. Fifth St.
Burris, Floyd L. . . . 731 Spring St.
Carlson, Norman R. . . 229 E. 5th St.
Donovan, Stephen J.
916 Washington St.
Fargher, Francis M.
723 Franklin St.
Feerer, Donald 117 W. Seventh St.
Flaherty, Walter T. . . Warren Bldg.
Gardner, Melvin D.
801 Washington St.
Gardner, Russell A.
801 Washington St.
Gilmore, Russell A.
301 Warren Bldg.
Grissom, Robert L.
801 Washington St.
Henderson, N. C.
622 1/2 Franklin St.
Hillenbrand, Charles Warren Bldg.
Jones, King Solomon
328 1/2 Franklin St.
Kemp, John T. 122 E. 7th St.
Kerrigan, Robert L.
916 Washington St.
Killough, Aimee R.
731 Washington St.
Kling, Victor F. . . . 507 Warren Bldg.
Kohrman, Benjamin M.
123 E. 5th St.
Krieger, George M.
701 Washington St.
Kubik, Francis J. 201 E. Eighth St.
Lava, Irving M. . . . 125 E. 5th St.
Meyer, Milo G. 801 Washington St.
Piazza, Leonard F.
404 Warren Bldg.
Plank, C. Robert . . . 732 E. Pine St.
Reed, Ann M. 123 E. Fifth St.
Reed, Nelle 501 Pine St.
Robrock, Lawrence M.
315 Warren Bldg.
Saide, Robert A.
1501 Washington St.
Spinning, A. L. (H)
130 Superior St.
Stephenson, Lewis E.
901 Washington St.
Straus, David C. . . . 123 E. Fifth St.
Weeks, Patrick H. Box 41
Wilson, Leroy A. 501 Pine St.

LaPORTE COUNTY

(LaPorte—Continued)

Weinstock, Adolph. Rolling Prairie
 Moosey, Louis. Union Mills
 Hetman, Mitchell J. Westville
 Benz, Owen. Wanatah
 Thomas, Wesley M. Westville

LAWRENCE COUNTY

Bedford

Allen, L. Howard
 305 Citizens Nat. Bank Bldg.
 Austin, Richard P.
 209 Citizens Nat. Bank Bldg.
 Bridwell, Edgar. 1317 L St.
 Byers, Norman R. 904 I St.
 Dusard, Joseph C.
 304 Citizens Nat. Bank Bldg.
 Edmonds, Kendrick. . . . 1110 R St.
 Emery, Charles B. . . . 1027 15th St.
 Emery, Charles H. (H)
 1027 15th St.

Fountaine, Thomas J.
 200 Citizens Nat. Bank Bldg.
 Hammel, Howard T.

Citizens Nat. Bank Bldg.
 Martin, Frank D. 1501 I St.
 Meyer, Orlando L. . . . 1317 L St.
 Newland, Arthur E. . . 1112 15th St.
 Pearson, John R.

Citizens Nat. Bank Bldg.
 Ragsdale, Harrison C.
 200 Citizens Nat. Bank Bldg.

Robertson, Moorman O.
 400 Citizens Nat. Bank Bldg.
 Scherschel, John P. . . . 1711 H St.
 Smallwood, Robert B.

204 Citizens Nat. Bank Bldg.
 Speheger, Benjamin A.
 400 Citizens Nat. Bank Bldg.

Stone, Charles E.
 VonRitz Theatre Bldg.
 Wohlfeld, Julius B. . . 1124 16th St.
 Woolery, Richard

207 Citizens Nat. Bank Bldg.
 Wynne, Roland E.

301 Citizens Nat. Bank Bldg.
 Hamilton, James R. . . . Mitchell
 Oswalt, James Telfer. . . Mitchell
 Strickland, William B. . . Mitchell
 Dollens, Claude. Oolitic
 Middleton, Thomas O.

739 S. Millvale Ave.,
 Pittsburgh, Pa.

MADISON COUNTY

Carpenter, John L. . . . Alexandria
 Gaunt, Everett W. . . . Alexandria
 Gibson, John J. (H) . . . Alexandria
 Keller, Frank G. (H) . . Alexandria
 Overpeck, George H. . . Alexandria
 Shafer, Richard H. . . . Alexandria

Anderson

Aagesen, Walter J.
 615 Citizens Bank Bldg.
 Armington, Charles L.
 655 Citizens Bank Bldg.
 Armington, John C.
 657 Anderson Bank Bldg.
 Armington, Robert L.
 318 Citizens Bank Bldg.

Austin, Maynard A.
 238 W. 12th St.

Ayres, Kenneth D.
 704 Anderson Bank Bldg.

Baughn, William L.
 1635 W. 12th St.

Blassaras, Christ. 2005 Broadway

Boylan, Malcolm

Delco-Remy Medical Dept.
 Brauchla, Carl H. . . 117 W. 17th St.
 Brock, Earl E. . . . 931 Meridian St.
 Buckles, David L. St. John's Hosp.
 Charles, Etta (H) . . 504 W. 11th St.
 Collins, Albert W. (H)
 1834 Broadway

Conrad, Ernest M. (H)
 2124 Meridian

Coy, Francis Matthew
 534 Citizens Bank Bldg.

Dixon, Rex W. 934 W. 8th St.
 Doenges, James L.

631 Citizens Bank Bldg.
 Drake, John C.

604 Anderson Bank Bldg.
 Ellis, Seth W. 335 W. 5th St.

Elsten, Aubrey W.
 704 Anderson Bank Bldg.

Erehart, Archie D.
 714 Anderson Bank Bldg.

Fisher, Warren E.
 St. John's Hospital

Gante, Henry W.
 1110 N. Meridian St.

Guthrie, Francis C.
 412 Anderson Bank Bldg.

Hart, William D.
 515 Citizens Bank Bldg.

Hensler, Benton M. 12 W. 29th St.
 Jarrett, Paul E.

315 Citizens Bank Bldg.
 Jones, Albert T.

712 Anderson Bank Bldg.
 Jones, Horace E.

1110 Meridian St.
 Kelly, Wendell C. . . . 704 E. 8th St.

King, Bernard A.
 1110 N. Meridian St.

King, Joseph W.
 1110 N. Meridian St.

Kopp, Otis A. 1110 N. Meridian St.
 Lamey, James L.

447 Citizens Bank Bldg.
 Lamey, Paul T.

423 Citizens Bank Bldg.
 Larmore, Joseph L.

712 Anderson Bank Bldg.
 Larmore, Sarah M.

1812 Nichol Ave.
 Litzenberger, Sam W.

622 Citizens Bank Bldg.
 Long, Paul L.

710 Anderson Bank Bldg.
 Miley, Weir M. . . . 718 Madison St.

McDonald Vergil G.
 1110 Meridian St.

Meister, Doris. Citizens Bank Bldg.
 Metcalf, George B.

931 Meridian St.
 Morris, Robert A.

2003 Meridian St.
 Nelson, Paul L. . . . 330 West 7th St.

Nesbit, Leonard L.
 415 Citizens Bank Bldg.

Patterson, William K.
 St. John's Hospital

Polhemus, Warren C.
 1803 Pearl St.

Quickel, Daniel S. (H)
 5 Griffith Bldg.

Reed, Roger R. 232 W. 12th St.
 Rosenbaum, Lloyd E.

647 Citizens Bank Bldg.
 Ross, Guy E.

661 Citizens Bank Bldg.

Rozelle, Clarence V.

615 Citizens Bank Bldg.
 Sharp, William L.
 449 Citizens Bank Bldg.
 Swan, Richard C. . . . Delco Remy
 Tracy, Julius R. . . . 738 W. 8th St.
 Webb, Harry. 2419 Main St.
 Wilder, Gordon B.

612 Anderson Bank Bldg.
 Wilkinson, Roger L. . . 4 E. 38th St.
 Williams, Francis. . . 1132 Central
 Williams, Robert H.

1132 Central Ave.
 Willson, Canby L.

2003 Meridian St.
 Wright, Cecil S.

523 Citizens Bank Bldg.
 York, Arthur F.

602 Citizens Bank Bldg.
 Zierer, Reuben O. 931 Meridian St.

Cullipher, Jeremiah E. (H) Elwood
 Fitzpatrick, H. W. Elwood

Hanson, Martin F. Elwood
 Hoppenrath, Wesley M. . . Elwood

Hoppenrath, William H. (H) Elwood

Laudeman, Walter A. . . . Elwood
 Ploughe, Monroe L. (H) . . Elwood

Ploughe, Ralph R. Elwood
 Scea, Wallace A. Elwood

Bishop, Harry A. Frankton
 Maxon, Roy V. Lapel

Rinne, John I. Lapel
 Bridges, William L. . . . Markleville

McLaughlin, Calvin P. . . Pendleton
 McVaugh, Charles C. . . Pendleton

Sisson, Helen M. Pendleton
 Irwin, Seth. Summitville

VanNess, William C. . . Summitville

MARION COUNTY

Fisher, Gerald E. Acton
 Berger, Morley. 902 Main

Beech Grove
 Kim, Y. D. 136 N. Seventeenth

Beech Grove
 Paulissen, G. T. . . . St. Francis Hosp.

Beech Grove
 Ramage, Walter F. . . . 244 S. First

Beech Grove
 Rhea, James C. 801 Main

Beech Grove
 Hade, F. L. Box 43, Bridgeport

Camby
 Zerfas, Leon. Cumberbund

Indianapolis

A

Adkins, Harold C. . . 409 E. 30th (5)
 Adkins, O. C. 3635 Watson Rd. (5)

Albertson, Frank P.
 5304 W. Washington (21)

Aldrich, Harry D.
 401 Hume Mansur Bldg. (4)

Aldrich, Howard
 4316 E. Washington (1)

Alexander, Ezra D.
 617 Indiana, No. 304 (2)

Allen, R. T. 1909 Eisenhower (24)
 Alvis, Edmond O.

320 Hume Mansur Bldg. (4)
 Anderson, Ralph J.

718 Hume Mansur Bldg. (4)
 Anderson, W. C. 1098 W. Mich. (7)

Appel, Richard H.
 603 Hume Mansur Bldg. (4)

Arbogast, J. L.
 I. U. Med. Center (7)

Arbuckle, W. E. . . . 1156 Lee (21)

MARION COUNTY (Indianapolis—Continued)

Arlook, T. D. . . . General Hosp. (7)
 Arnold, A. L. 607 E. Maple Rd. (5)
 Aronson, Sidney S.
 618 Hume Mansur Bldg. (4)

B

Bachmann, A. J. . . . 207 W. 34th (8)
 Bahr, Max A.
 Central State Hospital (22)
 Bakemeier, Otto H.
 5503 E. Washington (19)
 Balch, James F.
 709 Hume Mansur Bldg. (4)
 Ball, Joseph E. . . . 5039 E. 10th (1)
 Banister, R. F. . . . 2958 Central (5)
 Banks, H. M. . . . Methodist Hosp. (7)
 Barrett, D. C. . . . 1098 W. Mich. (7)
 Barry, M. Joseph, Sr.
 508 Doctors' Bldg. (4)
 Barry, Maurice J., Jr.
 I. U. Medical Center (7)
 Bartle, James L.
 7450 Pendleton Pike (18)
 Bartley, Max D.
 803 Hume Mansur Bldg. (4)
 Batman, Gordon W.
 723 Hume Mansur Bldg. (4)
 Battersby, J. Stanley
 I. U. Medical Center (7)
 Batties, P. A. 308 Walker Bldg. (2)
 Bauer, Thomas B.
 1015 Hume Mansur Bldg. (4)
 Baum, Harry . . . 1212 W. 36th (23)
 Beach, Robert R. . . 2630 E. 10th (1)
 Bean, Joseph S. General Hosp. (7)
 Beasley, Thomas J.
 428 Bankers Trust Bldg. (4)
 Beaver, H. W. . . . 11 E. Raymond (2)
 Bechtol, L. D. Methodist Hosp. (7)
 Beck, E. M. . . . 633 E. Maple Rd. (5)
 Beckman, Henry F.
 5245 Washington Blvd. (20)
 Beeler, Raymond C.
 712 Hume Mansur Bldg. (4)
 Berger, Henry I. . . 3650 College (5)
 Berman, Jacob K.
 807 Hume Mansur Bldg. (4)
 Beverland, M. E. 3036 E. Wash. (1)
 Bibler, Lester D.
 811 Underwriters Bldg. (4)
 Bird, Charles R.
 301 Hume Mansur Bldg. (4)
 Blatt, A. E. . . . 3209 N. Meridian (8)
 Bloemker, E. F. . . . 2729 Shelby (3)
 Boaz, John J.
 302 Ind. Pythian Bldg. (4)
 Boggs, E. F. . . . 4104 Madison (3)
 Bohner, Caryle B.
 822 Hume Mansur Bldg. (4)
 Booher, N. R. 447 E. Maple Rd. (5)
 Booher, O. B. 447 E. Maple Rd. (5)
 Bower, Daniel L.
 3377 Forest Manor (18)
 Bowers, Don D.
 711 Underwriters Bldg. (4)
 Bowman, G. W. 1140 E. Market (2)
 Boyer, Edward B.
 624 Hume Mansur Bldg. (4)
 Boyer, Floyd A. . . 442 N. Drexel (1)
 Brady, Thomas A.
 320 Hume Mansur Bldg. (4)
 Brayton, John R.
 704 Underwriters Bldg. (4)
 Brayton, Lee . . . 3342 N. Illinois (8)
 Brodie, D. W. 817 C. of C. Bldg. (4)
 Brother, G. M. . . . 1098 W. Mich. (7)

Brown, A. E. 1220 S. Belmont (21)
 Brown, David E.
 520 Hume Mansur Bldg. (4)
 Brown, DeWitt W.
 I. U. Medical Center (7)
 Brown, Edward A. (H)
 201 Ftn. Sq. Th. Bldg. (2)
 Brown, F. T. . . . 2126 N. Talbot (2)
 Brown, Leland G.
 I. U. Medical Center (7)
 Brown, W. E. 802 C. of C. Bldg. (4)
 Browning, James S.
 3209 N. Meridian (8)
 Browning, W. M. . . 3740 Central (5)
 Brubaker, Elmer H. (H)
 624 E. 23rd (5)
 Bruetsch, Walter L.
 Central State Hosp. (22)
 Buck, C. E. . . . I. U. Med. Center (7)
 Buehl, R. F. . . . 1906 S. Meridian (2)
 Bundy, C. Merle 1098 W. Mich. (7)
 Burdette, Harold F.
 3202 N. Meridian (8)
 Burghard, Rolla D.
 3760 N. Sherman Dr. (18)
 Burney, L. E. . . . 1098 W. Mich. (7)
 Burnett, Arthur . . . I. U. Hosp. (7)
 Buttz, Rose J. P. . . 112 E. 13th (2)

C

Cahal, Ernest E. . . 2614 Shelby (3)
 Cahn, Hugo M. . . . 506 E. 30th (5)
 Call, Herbert F.
 321 Hume Mansur Bldg. (4)
 Calvy, William J.
 224 N. Meridian, No. 301 (4)
 Campbell, John A.
 I. U. School of Medicine (7)
 Canaday, Jas. W. 1229 Prospect (3)
 Caplin, Irvin . . . 2033 N. Harding (2)
 Caplin, Samuel S. . . 111 E. 30th (5)
 Carson, Wayne
 1011 Hume Mansur Bldg. (4)
 Carter, James C.
 502 Hume Mansur Bldg. (4)
 Carter, Oren E. . . . 668 E. 38th (5)
 Caseley, D. J. I. U. Med. Center (7)
 Cavitt, Robt. F. 1701 Thaddeus (3)
 Cayley, Frank J.
 Central State Hosp. (22)
 Chen, Ko Kuei Eli Lilly & Co. (6)
 Childs, W. E. . . . 3649 W. Mich. (8)
 Clark, Cecil P.
 922 Hume Mansur Bldg. (4)
 Clark, Cyrus J. 6325 Guilford (20)
 Clark, Lawson J.
 420 Hume Mansur Bldg. (4)
 Close, W. Donald
 809 Hume Mansur Bldg. (4)
 Coble, R. R. . . . 3311 N. Meridian (8)
 Cohn, J. V. Cent. State Hosp. (22)
 Collins, H. L. 985 N. Arlington (19)
 Collins, James N.
 712 Hume Mansur Bldg. (4)
 Conger, E. S. (H)
 326 K. of P. Bldg. (4)
 Conley, Jos. L. 2443 E. Wash. (1)
 Conway, Chester C.
 4402 E. New York (1)
 Conway, Glenn . . . 1620 S. East (25)
 Cook, Charles J. (H)
 2405 Carrollton (5)
 Copeland, Samuel J.
 427 Bankers Tr. Bldg. (4)
 Cornacchione, Matthew
 814 S. East (2)

Cortese, T. A. . . . 435 S. East (4)
 Courtney, John W.
 518 Hume Mansur Bldg. (4)
 Cox, Clifford E.
 720 Underwriters Bldg. (4)
 Cox, H. B. . . . 5316 E. Wash. (19)
 Craft, Kenneth L.
 1002 Hume Mansur Bldg. (4)
 Craig, Alexander
 1501 E. Maple Rd. (5)
 Crawford, J. A. . . . Riley Hosp. (7)
 Culbertson, Clyde G.
 Lilly Research Lab. (6)
 Cullen, Paul K.
 422 Hume Mansur Bldg. (4)
 Culloden, Wm. G. . . 710 E. 46th (5)
 Cunningham, John M.
 508 Hume Mansur Bldg. (4)
 Cuthbert, Marvin
 203 Hume Mansur Bldg. (4)

D

Dalton, John E.
 707-8 Hume Mansur Bldg. (4)
 Dalton, William W.
 St. Vincent's Hosp. (7)
 Daniel, John C.
 1008 Hume Mansur Bldg. (4)
 Davidson, N. C. . . . 3008 Clifton (23)
 Davis, John A. . . . 2719 E. Mich. (1)
 Davis, Sam J.
 908 Hume Mansur Bldg. (4)
 Day, Clark W.
 611 Bankers Tr. Bldg. (4)
 Deal, Eleanor H.
 1544 Main, Speedway (24)
 Dearmin, Robert M.
 3440 N. Meridian (8)
 DeArmond, Murray
 723 Hume Mansur Bldg. (4)
 Deever, John W. . . 4131 Shelby (3)
 DeMotte, C. Bowen
 808 C. of C. Bldg. (4)
 Denny, F. L. . . . 2724 W. 10th (22)
 Denny, J. W. . . . 5504 E. Wash. (19)
 Des Jean, Paul A.
 616 K. of P. Bldg. (4)
 DeWees, D. L. . . . 302 N. Bradley (1)
 Dilts, R. L. . . . 5376 E. Wash. (19)
 Dintaman, Paul G.
 432 Bankers Trust Bldg. (4)
 Dittmer, Thomas L.
 3315 N. Gladstone (1)
 Donato, Albert M. 1521 Shelby (3)
 Dorman, W. L. 5508 E. Wash. (19)
 Dowd, Jos. A. . . . 6202 College (20)
 Dryden, Gale E. 5 S. Belmont (22)
 Dugan, T. J. . . . 2540 W. Wash. (22)
 Dugan, William M.
 410 Hume Mansur Bldg. (4)
 Dunbar, Colin V.
 423 Hume Mansur Bldg. (4)
 Dunning, L. M. . . . 1561 College (2)
 Dyar, E. W. . . . 3202 N. Meridian (8)
 Dyke, R. W. . . . General Hospital (7)

E

Eastman, Jos. R., Jr.
 822 Hume Mansur Bldg. (4)
 Eaton, E. R. . . . 3120 N. Meridian (8)
 Ebert, J. Wayne . . . 509 Lincoln (3)
 Eberwein, John H.
 414 E. Fall Creek Pkwy. (5)
 Eckert, R. A. . . . Methodist Hosp. (7)

MARION COUNTY

(Indianapolis—Continued)

- Egbert, Roy . . . 2601 Roosevelt (18)
 Eicher, P. O. 3209 N. Meridian (8)
 Eikenberry, Hugh W.
 616 Bankers Trust Bldg. (4)
 Eldridge, Gail E. . . 1440 E. 46th (5)
 Ellis, Bert E.
 303 Hume Mansur Bldg. (4)
 Ellis, Davis W., Jr.
 4104 Madison Ave. (3)
 Emhardt, John T. 1621 S. East (2)
 Emhardt, John W. A.
 709 Underwriters Bldg. (4)
 Ensminger, L. A.
 908 Hume Mansur Bldg. (4)
 Enzor, Ora K. . . . 4216 College (5)
 Ernst, C. E. . . . 2611½ W. Mich. (22)
 Evans, Fred'k H. 606 N. Senate (2)
 Evans, Paul V. . . General Hosp. (7)
 Everly, Ralph V. . 4216 College (5)
- F
 Farrell, Jos. T. . . 2807. E. Mich. (1)
 Fausset, C. Basil
 408 Hume Mansur Bldg. (4)
 Ferrara, Joseph F.
 807 Hume Mansur Bldg. (4)
 Fisch, Chas. 5857 Kingsley Dr. (20)
 Fisher, John E. . . VA Hospital (22)
 Fisher, S. . . . Billings Hospital (16)
 Fisk, Frank B. . . 1200 Madison (6)
 Fitzgerald, William J.
 203 Ftn. Sq. Theatre Bldg. (3)
 Flanagan, M. B. . . 1701 N. Ill. (2)
 Flick, John J. . . . 1443 N. Penn. (2)
 Flora, Jos. O. . . 4317 W. Wash. (21)
 Folkening, Norval C.
 313 Ftn. Sq. Theatre Bldg. (3)
 Foreman, Harry L. 60 W. 30th (8)
 Forry, Frank I. U. Med. Center (7)
 Fosler, David W.
 710 Underwriters Bldg. (4)
 Foster, Ray T. . . General Hosp. (7)
 Fouts, Paul J.
 522 Hume Mansur Bldg. (4)
 Franklin William L.
 508 Hume Mansur Bldg. (4)
 Frazin, Bernard. Billings VA Hosp.
 Fromhold, W. A. . . 743 S. East (2)
 Fry, Robert D.
 612 Hume Mansur Bldg. (4)
 Fullerton, Robt. L. 3665 N. Ill. (8)
 Funkhouser, A. G.
 702 Underwriters Bldg. (4)
 Funkhouser, Elmer
 702 Underwriters Bldg. (4)
 Furgason, Paul C.
 1008 Hume Mansur Bldg. (4)
 Furniss, S. A. . . . 401 Indiana (2)
- G
 Gabe, William E.
 612 Hume Mansur Bldg. (4)
 Gaddy, E. T. . . . 2602 W. Wash. (22)
 Gallup, P. R. . . . 601 Inland Bldg. (4)
 Gambill, William D.
 1019 Hume Mansur Bldg. (4)
 Gammieri, R. L. . . 3326 Clifton (23)
 Garber, J. Neill
 1024 Hume Mansur Bldg. (4)
 Garceau, George J.
 508 Hume Mansur Bldg. (4)
 Gardiner, Sprague H.
 314 Hume Mansur Bldg. (4)
 Gardner, Buckman
 2952 Central Ave. (5)
 Garfield, M. D. . . . 3705 College (5)
 Garner, Wm. . . . 2911 E. 10th (1)
- Garner, W. S. . . . 2911 E. 10th (1)
 Garrett, John D. (H)
 510 Doctors' Bldg. (4)
 Garrett, Robert A.
 I. U. Medical Center (7)
 Gastineau, Frank M.
 407 Hume Mansur Bldg. (4)
 Gatch, Willis D.
 605 Hume Mansur Bldg. (4)
 Geider, Roy A. . . 1443 Prospect (3)
 Geller, Samuel. 146 W. 26th St. (8)
 George, Chas. L. . . 507 E. 34th (5)
 Gibson, Greta M.
 3140 N. Meridian, No. 206 (8)
 Gick, Herman H. 2705 E. Mich. (1)
 Gifford, Fred E.
 710 Hume Mansur Bldg. (4)
 Gillespie, Charles F.
 3209 N. Meridian (8)
 Gillespie, Jacob E.
 523 Hume Mansur Bldg. (4)
 Givner, David
 Billings VA Hospital (16)
 Glass, Robert L.
 608 Hume Mansur Bldg. (4)
 Glendening, John L.
 132 Insurance Bldg. (4)
 Goldman, Sam'l. 5112 E. Mich (19)
 Goodwin, Caroline M.
 1220 Pickwick Pl. (8)
 Gosman, James H.
 407 Hume Mansur Bldg. (4)
 Graf, John P. I. U. Med. Center (7)
 Graves, John W. . 4734 E. 10th (19)
 Green, Harrison
 1011 Hume Mansur Bldg. (4)
 Green, Oscar. I.U. Med. Center (7)
 Greist, John H.
 202 Hume Mansur Bldg. (4)
 Griffith, Ross E. . . 401 E. 34th (5)
 Grisell, Ted L.
 504 Hume Mansur Bldg. (4)
 Gustafson, Gerald W.
 314 Hume Mansur Bldg. (4)
 Gutelius, Charles B.
 900 Underwriters Bldg. (4)
- H
 Habich, Carl
 702 Hume Mansur Bldg. (4)
 Hadden, Claude E.
 424 Hume Mansur Bldg. (4)
 Hadley, David
 809 Hume Mansur Bldg. (4)
 Hadley, Murray N.
 809 Hume Mansur Bldg. (4)
 Haggard, Edmund B.
 806 Board of Trade Bldg. (4)
 Hahn, E. Vernon
 914 Hume Mansur Bldg. (4)
 Hall, Frank M.
 701 Board of Trade Bldg. (4)
 Hall, Jack R. . . . 3342 N. Illinois (8)
 Hallam, F. Tulley
 1134 State Life Bldg. (4)
 Hamer, H. G. . . . 1711 N. Capitol (7)
 Hammond Ruben C.
 I. U. Medical Center (7)
 Hampshire, Donald R.
 1443 N. Pennsylvania (2)
 Hancock, J. C. . . 2226 W. Mich. (22)
 Hanna, Thomas A., 1462 Main St.
 Speedway City (24)
 Hansell, R. M. . . . 7 N. Euclid (1)
 Harcourt, Allan K.
 812 C. of C. Bldg. (4)
 Harden, Murray
 3557 N. Sherman Dr. (1)
- Harding, Myron S.
 308 Hume Mansur Bldg. (4)
 Harding, M. Richard
 308 Hume Mansur Bldg. (4)
 Hare, Earl H. . . . VA Hospital (22)
 Hare, Laura
 404 Hume Mansur Bldg. (4)
 Harger, Robert W.
 I. U. Medical Center (7)
 Harold, Albert H.
 7510 Allisonville Rd. (44)
 Harold, Norris E. (H)
 434 Bankers Trust Bldg. (4)
 Harris, Carl B.
 319 Hume Mansur Bldg. (4)
 Harris, Paul N. Eli Lilly & Co. (6)
 Hasler, Norman B.
 Sunnyside San. (44)
 Haslinger, Clarence J.
 2151 E. New York (1)
 Hatfield, B. F.
 802 C. of C. Bldg. (4)
 Hatfield, Jack J.
 802 C. of C. Bldg. (4)
 Hatfield, N. W. 2032 N. Rural (18)
 Hawk, James H.
 514 Hume Mansur Bldg. (4)
 Haymond, Jos. L. . . 605 E. 38th (5)
 Hays, Everett L.
 Billings Hosp. (16)
 Hedrick, P. W. . . . 654 E. 54th (20)
 Heinrichs, Harry H.
 705 Bankers Trust Bldg. (4)
 Heinz, Dorothy C. V.
 Ind. Council for Mental Health,
 State Fairgrounds (5)
 Hendricks, John D.
 2230 N. Delaware (5)
 Hendricks, John W.
 911 Hume Mansur Bldg. (4)
 Henry, Alvin L. General Hosp. (7)
 Henry, Russell S.
 725 Hume Mansur Bldg. (4)
 Hepburn, C. K.
 524 Hume Mansur Bldg. (4)
 Herrmann, Gordon T.
 I. U. Medical Center (7)
 Hetherington, A. M.
 4121 E. New York (1)
 Heubi, J. E. . . . 668 E. Maple Rd. (5)
 Hickman, W. F. . . 1210 Oliver (21)
 Hill, Edward C.
 Station Hosp., Ft. Harrison (16)
 Himebaugh, James R. S.
 507 S. Sherman Dr. (3)
 Himler, James M.
 809 Underwriters Bldg. (4)
 Hine, Ulis B. 4808 E. Michigan (1)
 Hines, Don C. . . Eli Lilly & Co. (6)
 Hippensteel, Russell R.
 401 E. 34th (5)
 Hodges, Fletcher. 3160 N. Penn. (5)
 Hofmann, John W.
 323 Hume Mansur Bldg. (4)
 Hollingsworth, A. A.
 4032 E. Washington (1)
 Hollis, W. H. . . . General Hospital (7)
 Holman, J. E., Jr. 3315 E. 10th (1)
 Holman, Jerome E., Sr.
 523 Bankers Trust Bldg. (4)
 Hood, Ainslee A. 1413 Roache (23)
 Horwitz, Thomas
 423 Hume Mansur Bldg. (4)
 Houseworth, John H.
 1301 College (2)
 Howell, Joseph D.
 760 Bankers Trust Bldg. (4)

MARION COUNTY

(Indianapolis—Continued)

Howell, Robert D.
900 Underwriters Bldg. (4)
Hoyt, L. H. Methodist Hosp. (7)
Huber, Carl P.
I. U. Medical Center (7)
Hudson, F. J. 3440 N. Meridian (8)
Hughes, J. E. 1628 Carrollton (2)
Hughes, Richard R.
I. U. Medical Center (7)
Hughes, William F. (H)
401 Hume Mansur Bldg. (4)
Hummons, H. L. 729½ N. West (2)
Hurt, L. B. 635 E. 59th (20)
Hurt, Paul T. 4151 N. Penn. (5)
Huse, William M.
St. Vincent's Hospital (7)
Hynes, R. T. 633 E. Maple Rd. (5)

I

Irwin, Glenn W., Jr.
I. U. Medical Center (7)
Iske, Paul G.
1015 Hume Mansur Bldg. (4)

J

Jackson, Frederick E.
510 Doctors' Bldg. (4)
Jackson, James W.
1098 W. Michigan (7)
Jackson, Jesse L. 3001 E. 10th (1)
Jacobs, Harry A.
332 Bankers Trust Bldg. (4)
Jaeger, A. S.
430 Bankers Trust Bldg. (4)
Jaquith, Orville S. (H)
261 Blue Ridge Rd. (8)
Jay, A. N. 3120 N. Meridian (8)
Jeffries, Kenneth I.
807 Virginia Ave. (3)
Jenkins, Robert E.
707 Hume Mansur Bldg. (4)
Jennings, Frank L.
Sunnyside Sanatorium (44)
Jewett, Joe H.
3120 N. Meridian (8)
Jewett, Lawrence (H)
6497 Broadway (20)
Jewett, Robt. E. 1098 W. Mich. (7)
Jinks, C. H. 4216 College (5)
Jobes, James E.
305 Traction Terminal Bldg. (4)
Jobes, Norman E. (H)
305 Traction Terminal Bldg. (4)
Johnson, Thomas W.
529 Bankers Trust Bldg. (4)
Johnson, William F.
2121 N. Harding (2)
Johnston, D. D.
VA Regional Office (4)
Jones, David E.
828 C. of C. Bldg. (4)
Jones, F. P. 4305 E. Mich. (1)
Joseph, Rex M. 1621 S. East (2)

K

Kahler, M. V. 2338 W. Mich. (22)
Kahn, A. J. 3120 N. Meridian (8)
Kahn, H. L. 3120 N. Meridian (8)
Kalb, E. L. 658½ Fairfield (5)
Kammen, Leo 3414 Clifton (23)
Kammen, Robt. 3202 W. 16th (22)
Katterjohn, James C.
313 Hume Mansur Bldg. (4)
Kauffman, Nelson N.
323 Hume Mansur Bldg. (4)

Kauffman, Sidney A.
226 Hume Mansur Bldg. (4)
Keenan, R. L. 812 C. of C. Bldg. (4)
Keever, Chas. H. 5214 College (20)
Keiser, Venice D.
646 Bankers Trust Bldg. (4)
Kelley, Clement E.
Methodist Hospital (7)
Kelly, Don E.
702 Underwriters Bldg. (4)
Kelly, John F.
517 Hume Mansur Bldg. (4)
Kelly, W. F. 5503 E. Wash. (19)
Kelly, W. M. 5376 E. Wash. (19)
Kempf, Gerald F. 307 City Hall (4)
Kendrick, William M.
1829 E. 46th (5)
Kennedy, Hall
2152 N. Meridian St. (2)
Kennedy, H. F. 1105 Prospect (3)
Kerr, Charles M. 321 S. Temple (1)
Kerr, Harry R. 2817 E. Wash. (1)
Ketcham, Jane M.
514 Hume Mansur Bldg. (4)
Kilgore, B. W. 3133 E. 38th (18)
Kime, Edwin N.
711 Underwriters Bldg. (4)
King, Wm. F. 1098 W. Mich. (7)
Kingsbury, John K.
5462 E. Washington (19)
Kinzel, Robert J. W.
3120 N. Meridian (8)
Kirklin, Oren L.
817 Hume Mansur Bldg. (4)
Kirtley, William R.
Lilly Research Lab. (6)
Kiser, Edgar F.
226 Hume Mansur Bldg. (4)
Kissinger, C. C. VA Hospital (44)
Kitterman, Harry E.
510 Hume Mansur Bldg. (4)
Klain, Benj. V. 4157 College (5)
Kloess, Edward J.
Station Hosp, Ft. Harrison (16)
Klotz, Jos. G. Methodist Hosp. (7)
Kneidel, J. H. General Hosp. (7)
Knowles, C. Y. 4625 E. 10th (1)
Kohlstaedt, George W.
422 Hume Mansur Bldg. (4)
Kohlstaedt, Karl C.
422 Hume Mansur Bldg. (4)
Kohlstaedt, Kenneth G.
General Hospital (7)
Koons, Karl M.
922 Hume Mansur Bldg. (4)
Kopp, Herschel S.
975 N. Emerson (19)
Kornafel, L. H.
608 K. of P. Bldg. (4)
Kraft, Bennett
760 Bankers Trust Bldg. (4)
Kuehn, Carl C. 1098 W. Mich. (7)
Kuntz, Herman W.
501 Hume Mansur Bldg. (4)
Kurtz, Fred B.
315 Bankers Trust Bldg. (4)
Kurtz, Philip L. 668 E. 38th (5)
Kwitny, I. J. 3209 N. Meridian (8)

L

LaDine, C. B. 2440 Station (18)
Lamb, Emmett B.
205 Hume Mansur Bldg. (4)
Lamb, Russell W.
205 Hume Mansur Bldg. (4)
Lamber, Chet K.
912 Hume Mansur Bldg. (4)

Langdon, Harry K.
3264 N. Pennsylvania (5)
Laramore, Ward
Billings VA Hospital (44)
Larkin, Bernard J.
305 Hume Mansur Bldg. (4)
Lawler, Geo. F. 3934 E. 10th (1)
Layman, Daniel W. (H)
1236 N. New Jersey (2)
Leasure, J. Kent
611 Hume Mansur Bldg. (4)
Leatherman, Harter L.
1531 Broadway (2)
Leff, Abe H. 712 E. 52nd (5)
Leffel, J. M. 3209 N. Meridian (8)
Leiter, Arthur
VA Regional Office (4)
Leonard, Henry S.
303 Hume Mansur Bldg. (4)
Leser, Ralph U.
207 Hume Mansur Bldg. (4)
Levi, Leon 40 W. 38th (8)
Levin, Ralph T. VA Hospital (22)
Lewis, James R. 808 Fletcher (3)
Libbert, Edwin L.
VA Regional Office (4)
Lichtenberg, Melvin 535 E. 38th (5)
Lidikay, Edward C.
915 Hume Mansur Bldg. (4)
Lindenberg, Paul G.
1402 N. Olney (1)
Ling, John F.
I. U. Medical Center (7)
Lingeman, Edward L.
411 Hume Mansur Bldg. (4)
Lingeman, R. E. General Hosp. (7)
Link, Goethe
608 Ind. Pythian Bldg. (4)
Littell, J. Jerome
603 Hume Mansur Bldg. (4)
Little, John W. (H)
2735 E. 10th (1)
Lochry, Ralph L.
St. Vincent's Hospital (7)
Loehr, William M.
712 Hume Mansur Bldg. (4)
Lomax, C. C. 2017 E. 52nd (5)
Long, Wm. H. 730 W. 30th (8)
Loomis, Norman S.
804 Hume Mansur Bldg. (4)
Lord, G. C. 104 E. Maple Rd. (5)
Love, Geo. N. Methodist Hosp. (7)
Ludwig, Oscar D. 5433 Madison (3)
Lukenbill, E. D. 661 E. 49th (5)
Lundberg, Ralph A.
Station Hosp., Ft. Harrison
Lybrook, William B.
3749 N. Keystone (18)

Mc

MacDonald, John A.
408 Hume Mansur Bldg. (4)
McBride, James S.
810 Hume Mansur Bldg. (4)
McCallum, Joseph T. C.
237 W. 46th (8)
McCarthy, D. J.
507 Hume Mansur Bldg. (4)
McCartney, Donald H.
501 Hume Mansur Bldg. (4)
McCaskey, Carl H.
608 Guaranty Bldg. (4)
McCormick, C. O., Jr.
621 Hume Mansur Bldg. (4)
McCormick, C. O., Sr.
621 Hume Mansur Bldg. (4)
McCown, Percy E.
521 Hume Mansur Bldg. (4)

MARION COUNTY
(Indianapolis—Continued)

- McDevitt, Daniel R.
3202 N. Meridian (8)
- McGrath, M. F. 1929 E. 38th (18)
- McGuff, P. E. 605 E. Maple Rd. (5)
- McIntyre, Charles J.
414 Hume Mansur Bldg. (4)
- McIntyre, J. M.
806 Hume Mansur Bldg. (4)
- McKinley, A. D. I. U. Hospitals (7)
- McKinley, Joseph I. U. Hosp. (7)
- McMillan, Frederick
1110 Odd Fellows Bldg. (4)
- McNamara, John P.
4016 E. Michigan (1)
- McQuiston, Ralph J.
608 Guaranty Bldg. (4)
- McTurnan, R. W. 5646 N. Ill. (8)
- M
Mackey, H. S. 4309 Central (5)
- Mackey, J. E. General Hosp. (7)
- Magennis, Herbert L.
468½ W. Washington St. (4)
- Maly, Charles H.
VA Regional Office (4)
- Manion, Marlow W.
601 Hume Mansur Bldg. (4)
- Mann, Mortimer
323 Hume Mansur Bldg. (4)
- Manning, Joseph C.
601 Hume Mansur Bldg. (4)
- Manning, K. Randolph
723 Hume Mansur Bldg. (4)
- Marshall, Albert L., Jr.
3465 Carrollton Ave. (5)
- Marshall, A. L.
3914 Guilford Ave. (5)
- Marshall, C. R. 43 W. 30th (8)
- Martin, Charles F., Jr.
VA Hospital (22)
- Martin, H. E. 1200 Madison (6)
- Martin, L. H. 2626 W. Wash. (22)
- Martz, Bill L.
4571 Fall Creek Blvd. (19)
- Martz, Carl D.
508 Hume Mansur Bldg. (4)
- Masters, John B. VA Hospital (22)
- Masters, John M.
805 Hume Mansur Bldg. (4)
- Masters, Robert J.
805 Hume Mansur Bldg. (4)
- Matthew, W. Burleigh
520 Hume Mansur Bldg. (4)
- Matthews, B. J. 4612 E. 10th (1)
- Matthews, William M.
966 N. Graham (19)
- Megenhardt, D. S.
1015 Hume Mansur Bldg. (4)
- Meiks, Lyman T. Riley Hosp. (7)
- Melloh, Ardis 2821 E. 10th (1)
- Mendenhall, Clarence D.
4502 E. Washington (1)
- Mendenhall, William E.
515 N. Rural (1)
- Mentendiek, Maurice H.
205 Hume Mansur Bldg. (4)
- Mericle, Earl W.
209 Hume Mansur Bldg. (4)
- Merrell, Paul
914 Hume Mansur Bldg. (4)
- Mertz, H. O. 1711 N. Capitol (7)
- Michael, Amos C.
1040 W. Michigan St. (7)
- Micheli, Arthur J.
920 Underwriters Bldg. (4)
- Middleton, H. N. 1828 N. Ill. (2)
- Miller, A. W. 207 E. Morris (2)
- Miller, Earl R.
Station Hosp., Ft. Harrison (16)
- Miller, J. Don
514 Hume Mansur Bldg. (4)
- Miller, John R.
Central State Hospital (22)
- Miller, R. S. 6140 College (20)
- Miller, Ray D. 3769 Park (5)
- Miller, Wm. T. 2411 E. 10th (1)
- Millikan, William J.
420 Hume Mansur Bldg. (4)
- Mitchell, Earl H.
2617 W. Michigan (22)
- Moenning, Walter P.
219 N. Pennsylvania (4)
- Mohler, Floyd W.
Methodist Hospital (7)
- Molt, William F.
529 Bankers Trust Bldg. (4)
- Montgomery, William F.
311 Hume Mansur Bldg. (4)
- Moore, Ben B.
414 Hume Mansur Bldg. (4)
- Moore, H. T. 3220 N. Sharon (22)
- Moore, Robert M.
1007 Hume Mansur Bldg. (4)
- Moriarty, John R. 198-C Saltsman,
Tyndall Towne (21)
- Morris, Jean 1311 N. Drexel (1)
- Morrison, Lewis E., II
503 Hume Mansur Bldg. (4)
- Morton, Walter P.
623 Hume Mansur Bldg. (4)
- Moser, Rollin H.
408 Hume Mansur Bldg. (4)
- Moss, H. B. 1849 Nowland (1)
- Mothersill, Mark H.
Eli Lilly & Company (6)
- Moulton, Lillian G.
1327 N. Pennsylvania (2)
- Moutoux, J. E. 2346 Shelby (3)
- Mozingo, A. E.
1129 S. Meridian (2)
- Mueller, Lillian B.
General Hospital (7)
- Muller, P. R. 3311 N. Meridian (8)
- Mumford, E. Bishop
320 N. Meridian (4)
- Myers, C. W. General Hospital (7)
- Myers, Harold A.
Station Hosp., Ft. Harrison (16)
- Myers, Roy V. 1904 N. Rural (18)
- N
Nafe, Cleon A.
822 Hume Mansur Bldg. (4)
- Nay, Richard M.
214 Hume Mansur Bldg. (4)
- Need, L. T. 1927 S. Meridian (2)
- Neely, Alonzo S.
305 Fountain Square Bldg. (3)
- Nehil, Lawrence W.
1011 Hume Mansur Bldg. (4)
- Neier, Oliver C. (H)
5508 E. Washington (19)
- Nie, Louis W.
202 Hume Mansur Bldg. (4)
- Noble, Thomas B., Jr.
1008 Hume Mansur Bldg. (4)
- Noble, Thomas B., Sr. (H)
1008 Hume Mansur Bldg. (4)
- Nolting, H. F. 261 W. 40th (8)
- Nonte, Leo R.
Billings VA Hospital (16)
- Norman, Olin B.
922 Hume Mansur Bldg. (4)
- Norman, William H.
908 Hume Mansur Bldg. (4)
- Norris, Howard Lee
704 Hume Mansur Bldg. (4)
- Norris, Mary Alice
404 Hume Mansur Bldg. (4)
- Nourse, M. H. 1711 N. Capitol (7)
- Nugent, Edwin J.
Allison Division, GMC (6)
- O
Ochsner, H. C. Methodist Hosp. (7)
- O'Dell, T. A. 1122 Roache (23)
- Olvey, O. N. 3809 Central (5)
- Orders, Clark E.
440 Bankers Trust Bldg. (4)
- Otten, Claude F.
812 C. of C. Bldg. (4)
- Ottinger, Ross C.
912 Hume Mansur Bldg. (4)
- Owen, John E.
605 Hume Mansur Bldg. (4)
- Owens, T. C. 2823 N. Meridian (8)
- P
Padgett, Everett E.
424 Hume Mansur Bldg. (4)
- Pandolfo, Harry 2206 Madison (2)
- Parker, J. F. 1706 E. Wash. (1)
- Parker, Portia
2226 W. Michigan (22)
- Patton, M. T. 107 W. 30th (8)
- Peacock, R. C. General Hosp. (7)
- Pearson, Lyman R.
311 Hume Mansur Bldg. (4)
- Pebworth, Aubrey C.
1625 W. Morris (21)
- Peck, F. B. 740 S. Alabama (6)
- Peirce, Jas. D. Eli Lilly & Co. (6)
- Pennington Philip E.
958 N. Parker (1)
- Pennington, Walter E.
214 Hume Mansur Bldg. (4)
- Permer, Erwin 134 E. 30th (5)
- Peters, Robert John D.
3203 E. Michigan (1)
- Petranoff, Theodore V.
3367 W. Michigan (22)
- Pettijohn, F. L. (H)
2460 Central (5)
- Pfaff, Dudley A.
723 Hume Mansur Bldg. (4)
- Pfaff, John A. (H)
703 Hume Mansur Bldg. (4)
- Pfafflin, Charles A. (H)
445 Bankers Trust Bldg. (4)
- Pickett, Robert D.
408 Hume Mansur Bldg. (4)
- Pilcher, Jack E.
201 Hume Mansur Bldg. (4)
- Pollak, Lewis 1602 N. Penn. (2)
- Price, James O.
906 Hume Mansur Bldg. (4)
- Pryor, R. C. 6111 College (20)
- Q
Quigley, Jos. B. 2120 E. 10th (1)
- R
Rabb, F. M. 4146 N. Illinois (8)
- Rabb, H. S. 3139 E. 10th (1)
- Raber, Robt. M. VA Hospital (22)
- Rader, George S.
822 Hume Mansur Bldg. (4)
- Ramsey, Frank B.
201 Hume Mansur Bldg. (4)
- Reed, J. V. 820 C. of C. Bldg. (4)
- Reed, Robt. C. 969 W. 31st (23)
- Reed, Philip B. 1820 E. 10th (1)
- Rees, R. C. 6114 E. Wash. (19)
- Reese, Thos. V. 5417 Hibben (19)
- Reid, Chas. A. 2445 Shelby (3)
- Reisler, Simon
318 Bankers Trust Bldg. (4)

MARION COUNTY
(Indianapolis—Continued)

- Rhodes, Theodore D.
307 Hume Mansur Bldg. (4)
- Rice, R. M. 740 S. Alabama (6)
- Rice, Thurman B. 1098 W. Mich. (7)
- Richardson, Thad T.
5370 E. Washington (19)
- Richter, Arthur B.
720 Hume Mansur Bldg. (4)
- Ricketts, J. W.
806 Hume Mansur Bldg. (4)
- Ridgeway, Ora W. . . 411 E. 16th (2)
- Rigg, John F.
421 Hume Mansur Bldg. (4)
- Rinker, Earl B. . . . 22 E. 57th (20)
- Ritchey, James O.
608 Hume Mansur Bldg. (4)
- Ritter, Wayne L.
404 Hume Mansur Bldg. (4)
- Robb, John A.
238 Hume Mansur Bldg. (4)
- Robertson, Ray B.
6118 E. Washington (19)
- Roller, C. W. 1437 Shelby (3)
- Romberger, F. T., Jr.
3440 N. Meridian (8)
- Rosenak, Bernard D.
226 Hume Mansur Bldg. (4)
- Rosenbaum, David. . VA Hosp. (22)
- Rosenbaum, Irving, Jr.
712 E. 63rd (20)
- Ross, Alexander T.
I. U. Medical Center (7)
- Row, D. Hamilton
906 Hume Mansur Bldg. (4)
- Rubin, Gerald S.
620 Hume Mansur Bldg. (4)
- Ruddell, Karl R.
3202 N. Meridian (8)
- Ruddell, Keith R.
3202 N. Meridian (8)
- Rudensky, Herman
Billings VA Hosp. (16)
- Rudesill, Cecil L.
405 Hume Mansur Bldg. (4)
- Rudolph, Stephen J., Jr.
1638 N. Meridian (2)
- Rupel, Ernest
419 Hume Mansur Bldg. (4)
- Russell, R. H. . . . General Hosp. (7)
- Rust, Byron K. . . . 3740 Central (5)
- Ruth, Martin L.
4304 E. Washington (1)
- Rutherford, Cyrus W.
4601 N. Pennsylvania (5)
- Ryan, G. V. 2428 W. 16th (22)
- S
- Sacks, Harry J.
I. U. Medical Center (7)
- Sage, Russell A.
505 Hume Mansur Bldg. (4)
- Salb, John A.
650 Bankers Trust Bldg. (4)
- Salb, Max C.
826 C. of C. Bldg. (4)
- Salkin, Irwin
Robert Long Hospital (7)
- Salzman, Morris
1119 S. Meridian (2)
- Sanders, Harry M.
3760 N. Sherman Dr. (18)
- Sandorf, M. H. 1102½ Prospect (3)
- Schaefer, C. Richard (H)
224 N. Meridian, No. 20 (4)
- Schechter, John S.
3209 N. Meridian (8)
- Scheeter, William J.
I. U. Medical Center (7)
- Scheier, E. W. . . . 1706 Prospect (3)
- Schneider, C. J. 1008 N. Beville (1)
- Schuchman, G. . . . 3451 College (5)
- Schulze, H. A. . . . 98 N. Ewing (1)
- Schuster, D. W. . . . 1820 E. 10th (1)
- Schweitzer, Ada E. (H)
5736 N. Michigan Rd. (20)
- Scott, George 315 E. 33rd (5)
- Scott, I. W. 3209 N. Meridian (8)
- Scott, Samuel L. . . . VA Hosp. (22)
- Seaman, Charles F.
1010 Hume Mansur Bldg. (4)
- Seaton, Albert, American United
Life Ins. Co., Box 368 (6)
- Sedam, H. L. 4173½ College (5)
- Segar, Louis H.
226 Hume Mansur Bldg. (4)
- Sexson, H. T. 1301 College (2)
- Shafer, Marion R.
614 Hume Mansur Bldg. (4)
- Sheehan, F. G. 5503 E. Wash. (19)
- Sherster, Harry
1135 S. Meridian (25)
- Shobe, W. R. 617 N. West (2)
- Shuck W. A. 3311 N. Meridian (8)
- Shugart, Joseph A.
St. Vincent's Hosp. (7)
- Shullenberger, W. A.
3740 Central (5)
- Shumacker, Harris B., Jr.
I. U. Med. Center (7)
- Sicks, Okla. W.
1010 Hume Mansur Bldg. (4)
- Siekerman, C. W. 2612 Madison (3)
- Siersdorfer, Theodore N.
6003 W. Wash. (21)
- Sigmond, Harvey W.
301 Hume Mansur Bldg. (4)
- Sims, J. Lawrence
809 Hume Mansur Bldg. (4)
- Slocum, Y. K. . . . Billings Hosp. (16)
- Sluss, D. H. (H)
808 C. of C. Bldg. (4)
- Sluss, J. W. 808 C. of C. Bldg. (4)
- Smiley, Jas. H. . . . 4201 E. Mich. (1)
- Smith, D. J. Methodist Hosp. (7)
- Smith, David L.
723 Hume Mansur Bldg. (4)
- Smith, E. Rogers
822 Hume Mansur Bldg. (4)
- Smith, F. C. 983 N. Arlington (19)
- Smith, Jas. M. . . . 700 Test Bldg. (4)
- Smith, Lester A.
238 Hume Mansur Bldg. (4)
- Smith, Roy Lee
707 Underwriters Bldg. (4)
- Smith, W. F. 3424 College (5)
- Smith, William B.
2411 Northwestern (8)
- Smithson, Robert A.
I. U. Med. Center (7)
- Snider, Byron 2717 S. East (3)
- Solomon, Reuben A.
414 Hume Mansur Bldg. (4)
- Souter, M. C. 3360 N. Meridian (8)
- Sovine, J. W.
720 Hume Mansur Bldg. (4)
- Spahr, John F., Jr.
902 Hume Mansur Bldg. (4)
- Spalding, Joseph J.
706 Hume Mansur Bldg. (4)
- Sparks, A. J. VA Hospital (22)
- Sparks, Alan L.
1024 Hume Mansur Bldg. (4)
- Spink, Urbana 112 E. 13th (2)
- Spivey, R. J. 2616 N. Penn. (5)
- Spolyar, L. W. . . . 1098 W. Mich. (7)
- Sputh, Carl B., Jr.
301 Doctors Bldg. (4)
- Sputh, Carl B., Sr.
301 Doctors Bldg. (4)
- Stadler, H. E. 5508 E. Wash. (19)
- Stanley, Jno. S. . . . 307 City Hall (4)
- Stayton, C. A., Sr.
313 Hume Mansur Bldg. (4)
- Steele, Paul W. . . . VA Hospital (22)
- Stephens, D. E. . . . 6332 Guilford (20)
- Stephens, K. H.
501 Hume Mansur Bldg. (4)
- Stern, Nathan
601 Bankers Tr. Bldg. (4)
- Stevens, S. L. . . . General Hosp. (7)
- Stoelting, V. K.
I. U. Med. Center (7)
- Stone, Alvin T. . . . 6202 College (20)
- Stone, David F.
725 Hume Mansur Bldg. (4)
- Storey, D. E. 813 Broad Ripple (20)
- Storey, Jos. L. . . . 3434 N. Illinois (8)
- Storms, Roy B.
1014 Roosevelt Bldg. (4)
- Stroup, T. J. 216 K. of P. Bldg. (4)
- Stucky, E. K. 1355 Madison (2)
- Stump, T. A. Sunnyside San. (44)
- Stygall, J. H. 1221 N. Delaware (2)
- Sudranski, Herbert F.
624 Hume Mansur Bldg. (4)
- Sullivan, Thomas L.
28 E. 16th, No. 607 (2)
- Sutton, William E.
419 Hume Mansur Bldg. (4)
- Swan, John R.
915 Hume Mansur Bldg. (4)
- Swayne, Jap F. . . . 1410 E. Wash. (1)
- Symmes, Alfred T.
Lilly Research Clinic (7)
- T
- Talbott, Dan E.
1020 Hume Mansur Bldg. (4)
- Tanner, Henry S.
301 Hume Mansur Bldg. (4)
- Taylor, Clifford C.
St. Vincent's Hosp. (7)
- Taylor, Frederic W.
408 Hume Mansur Bldg. (4)
- Teague, Frank W.
501 Hume Mansur Bldg. (4)
- Teixler, Victor A.
224 Hume Mansur Bldg. (4)
- Terry, Willard B. G., Jr.
Methodist Hosp. (7)
- Tether, J. Edward
I. U. Med. Center (7)
- Tharpe, Ray 3202 N. Meridian (8)
- Thatcher, Hugh K., Jr.
110 W. Maple Rd. (8)
- Thielen, Albert E.
Naval Ord. Plant Hosp.
- Thom, Jay W.
704 W. Dr., Woodruff Pl. (1)
- Thom, Julia S.
704 W. Dr., Woodruff Pl. (1)
- Thomas, E. P. 463½ Blake (2)
- Thomas, L. I. 812 C. of C. Bldg. (4)
- Thomas, Morris E.
715 Underwriters Bldg. (4)
- Thompson, Charles F.
320 Hume Mansur Bldg. (4)
- Thompson, John V.
1221 N. Delaware (2)
- Thornburg, Kenneth E.
1015 Hume Mansur Bldg. (4)

MARION COUNTY

(Indianapolis—Continued)

- Thornton, Harold C.
St. Vincent's Hosp. (7)
Thurston, H. S. 2503½ Prospect (3)
Thurston, Herbert F.
818 Hume Mansur Bldg. (4)
Tinney, William E.
900 Underwriters Bldg. (4)
Tinsley, Frank W.
603 K. of P. Bldg. (4)
Tinsley, Walter B.
603 K. of P. Bldg. (4)
Tischer, E. Paul
208 Hume Mansur Bldg. (4)
Torrella, J. A. 5324 W. 16th (24)
Toumey, Fred L.
529 Bankers Tr. Bldg. (4)
Travis, J. C.
805 Underwriters Bldg. (4)
Trusler, Harold M.
1015 Hume Mansur Bldg. (4)
Tuchman, Jos. H. 845 Grove (3)
Tucker, R. L. 938½ E. 30th (5)
Tucker, Warren S.
414 Hume Mansur Bldg. (4)
- V
Vandivier, Robert M.
209 Hume Mansur Bldg. (4)
Van Dorn, Myron J.
Methodist Hosp. (7)
Van Fleet, Josephine
I.U. Med. Center (7)
Van Meter, C. P. 3419 E. 10th (1)
Van Nuys, J. D.
I.U. Med. Center (7)
Van Osdol, Harry A.
828 C. of C. Bldg. (4)
Van Tassel, C. J., Jr.
I.U. Med. Center (7)
Van Vactor, Helen D.
226 Hume Mansur Bldg. (4)
Vollrath, V. J. 5202 N. Illinois (8)
Voyles, Charles F. (H)
715 Underwriters Bldg. (4)
- W
Waldo, J. Thayer
610 Hume Mansur Bldg. (4)
Wales, E. de Wolfe (H)
1236 N. Penn. (2)
Walker, Frank C.
414 Hume Mansur Bldg. (4)
Walker, R. K. 413 E. 34th (5)
Waller, John I.
407 Hume Mansur Bldg. (4)
Walther, J. E. 3202 N. Meridian (8)
Ward, Wesley C. 116 E. 49th (5)
Warfel, Fredk. C. VA Hosp. (22)
Warman, Alvah P.
709 E. Maple Rd. (5)
Warren, Jno. C. 5444 College (5)
Warriner, James B.
Methodist Hosp. (7)
Warvel, John H.
614 Hume Mansur Bldg. (4)
Waterman, John H.
Child Guidance Clinic
I.U. Med. Center (7)
Waymire, E. S. 1827 College (2)
Wehrman, Jule O.
504 Hume Mansur Bldg. (4)
Weigand, Clayton G.
Lilly Research Lab. (6)
Weil, H. J. 443 N. Hamilton (1)
Weinland, George C.
1329 N. New Jersey (2)
- Weiss, Jason. 4909 W. 15th (24)
Weller, Charles A.
615 Hume Mansur Bldg. (4)
West, Jos. L. 6318 W. Wash. (21)
Westfall, B. K. 2901 E. 38th (18)
Westfall, John B.
2961 N. Sherman (18)
Westmoreland, R. E. VA Hosp. (22)
Weyerbacher, A. F.
709 Hume Mansur Bldg. (4)
Wheeler, John T. (H)
3130 N. Delaware (5)
White, Donald J.
502 Bankers Tr. Bldg. (4)
Whitehead, John M.
1544 Roosevelt (1)
Whitlock, F. E. 4032 E. Wash. (1)
Wiethoff, Clifford A.
General Hospital (7)
Wilkens, I. W. 1743 Shelby (3)
Williams, C. D. 2405 Station (18)
Williams, H. S., Jr. 115 E. 16th (2)
Williams, Luther (H)
3540 N. Penn. (5)
Wilmore, R. C. I.U. Med. Center (7)
Wilson, Leslie
Ft. Benj. Harrison (16)
Winters, Matthew. 508 E. 38th (5)
Wishard, William N., Jr.
1711 N. Capitol (7)
Wolfram, Don J.
208 Hume Mansur Bldg. (4)
Wood, D. E. 6325 Guilford (20)
Woodard, Abram S., Jr.
668 E. Maple Rd. (5)
Worley, J. P. 5831 E. Wash. (19)
Wright, J. William
301 Hume Mansur Bldg. (4)
Wright, Joseph W., Jr.
301 Hume Mansur Bldg. (4)
Wytenbach, F. C. 1154 Lee (21)
Wytenbach, John E.
503 Hume Mansur Bldg. (4)
- Y
Young, Jas. W. 6302 Guilford (20)
Young, J. M. 3209 N. Meridian (8)
Young, W. C. Eli Lilly & Co. (6)
- Z
Zell, E. H. 812 C. of C. Bldg. (4)
Zerfas, C. P. A. 2605 Shelby (3)
Zerfas, Phyllis K. 2605 Shelby (3)
Zix, Geraldine M.
514 E. 20th, Apt. 5 (2)
Lewis, Robert J. Lawrence
Asher, Ernest O. New Augusta
Asher, James W. New Augusta
Paynter, Morris B. Southport
Jones, George L. Wanamaker
Alward, John H. City Hosp.,
Akron, Ohio
Barnett, Ernest R. 219A S. Garfield,
Alhambra, Calif.
Bill, Robert O. Winter VA Hosp.,
Topeka, Kansas
Blackford, Roger W.
Southwest Clinic,
Russellville, Ark.
Boys, Floyd E. Univ. of Illinois,
Urbana, Illinois
Burt, James C. 620 W. 168th St.,
New York 32
Connerley, Marion L.
U. S. Naval Hosp.,
Chelsea 50, Mass.
Davis, George D. Mayo Clinic,
Rochester, Minn.

- DeLawter, Hilbert H. Haven San.,
Rochester, Mich.
Dester, Herbert E. Jagdeeshpur,
via Raipur, India
Dimond, E. Grey. Mass. Gen. Hosp.,
Boston 14, Mass.
Dublin, William B. VA Hospital,
Fort Logan, Colorado
Friedman, Herbert P. Carle Clinic,
Urbana, Illinois
Goodrich, Albert
N. Y. Postgraduate Hosp.,
New York City
Graf, John E. 4332 N. Kilbourn,
Chicago 41, Illinois
Griswold, Waite R.
U. S. Naval Hosp.,
Mare Island, Calif.
Hanley, Marshall J.
Queens General Hosp.,
Jamaica, N. Y.
Harvey, Verne K.
39 River Rd. Terrace,
Alexandria 14, Va.
Haskell, Cosa D. 1958 48th Ave.,
San Francisco, Calif.
Hetherington, John A. Mayo Clinic,
Rochester, Minn.
Hildrup, Don G. Fort Sill, Okla.
Jay, Robert P. 350 S. Hotel St.,
Honolulu, Hawaii
Joseph, Herbert L.
Barnard Skin and Cancer Hosp.,
St. Louis, Mo.
Kenoyer, Wilbur J. Fort Knox, Ky.
Lambert, C. W. 2400 S. Flower St.,
Los Angeles, Calif.
Lehman, Robert J.
Pilgrim State Hosp.,
Long Island, N. Y.
Meihaus, John E.
Sawtelle VA Hosp.,
Los Angeles, Calif.
Mitchell, Raymond E.
U. S. Marine Hosp.,
Ft. Stanton, New Mexico
Norwick, Sydney S.
15816 Via Riveria,
San Lorenzo, Calif.
Pebworth, James T. Box 124,
Tyrone, New Mexico
Ridgway, Alton H.
Belgian Congo, Africa
Rogers, Thomas P.
U. S. Naval Hosp.,
Long Beach, Calif.
Roll, Edmund C. Firland San.,
Seattle 55, Wash.
Sales, Louis M. VA Hosp.,
Lake City, Florida
Sheridan, Joseph L.
St. Elizabeth Hosp.,
Washington, D. C.
Slabaugh, Carlyle B.
1731 Brownlee Blvd.,
Corpus Christie, Texas
Stayton, Chester A., Jr.
Mayo Clinic, Rochester, Minn.
Steele, Brandt F. 1640 Pine St.,
Philadelphia, Pa.
Test, Charles E. Univ. of Chicago,
Chicago, Ill.
Teeter, E. J. Goodland, Kans.
Teter, George V., Jr.
U. S. Naval Hosp.,
Chelsea 50, Mass.

MARION COUNTY

(Indianapolis—Continued)

Unger, Abraham
VA Regional Office, Cleveland, O.
Weathers, Paul E. McGuire AFB,
Fort Dix, New Jersey
Williams, George D.
Lawson VA Hosp., Chamblee, Ga.

MARSHALL COUNTY

Johns, N. C. Argos
Kelly, Frank H. Argos
Sheller, Thomas G. Argos
Connell, Vactor O. Bourbon
Marshall, George L. Bourbon
Bowen, Otis Bremen
Cripe, Earl P. Bremen
Stine, Marshall E. Bremen
Schreiner, John E. Bremen
Baker, Milan D. Culver
Bills, Leroy F. R.R. 1, Culver
Reed, Donald Culver
Witham, Robert L. Culver
Connell, Paul S. Plymouth
Irey, Paul R. Plymouth
Kaler, James Plymouth
Klingler, Maurice O. Plymouth
Kubley, James D. Plymouth
Pomeroy, Rex K. Plymouth
Possolt, Thomas R. Plymouth
Robertson, James S. Plymouth
Stephens, R. Clarence (H)
Plymouth
Tripp, Harry D. Plymouth
Vore, L. W. Plymouth
Thompson, Alfred A. Tyner
Holtzendorff, Charles F. (H)
2344 Oakdale St.,
St. Petersburg, Fla.

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E. Amboy
Line, Homer E. Chili
Frybarger, Samuel S. Converse
Malott, Frederick R. Converse
Sennett, Wm. K. Macy
Waite, Earl L. Gilead
Rendel, Harold E. Mexico
Barnett, Ralph E. Peru
Berkebile, John B. Peru
Burrous, E. L. Peru
Carlson, Edward A. Peru
Ferrara, Donald W. Peru
Ferrara, Samuel J. Peru
Herd, C. R. Peru
Lynn, Frank M. (H) Peru
Malouf, Stephen D. Peru
Ridenour, David C. (H) Peru
Wildman, Roscoe E. Peru
Yarling, John E. (H) Peru

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Alexander, Stephen J.
306 Ben Hur Bldg.
Ball, Thomas Z. (H)
403 Ben Hur Bldg.
Burks, Jess Edwin
403 Ben Hur Bldg.

Cooksey, Thomas L. (H)
109½ S. Washington St.
Cornell, Robert A.
219 Ben Hur Bldg.
Daugherty, Fred N.
120 W. Pike St.
Dodds, Wemple Culver Hospital
Echternacht, Arthur P.
Culver Hospital
Haller, Thomas C. Ben Hur Bldg.
Humphreys, John W.
312 Jones Ave.
Kinnaman, Howard A.
206 Ben Hur Bldg.
Kirtley, James M.
416 Ben Hur Bldg.
Lingeman, Byron N.
419 Ben Hur Bldg.
Mount, William M.
413 Ben Hur Bldg.
Peacock, Norman F.
219 Ben Hur Bldg.
Pierson, Robert H. 305 E. Main St.
Pollom, Robert R. 306½ S. Water
Sharp, John L.
219 Ben Hur Bldg.

Straughan, Walter L.
Ben Hur Bldg.
Taylor, Willard M.
315 Ben Hur Bldg.
Wallace, Hawthorne C.
419 Ben Hur Bldg.
Otten, Ralph E. Darlington
Blix, Fred M. Ladoga
Denny, Frank T. Ladoga
Kindell, Hurschell D.
New Richmond
Bounnell, H. M. (H) Waynetown
Johnson, Frank D. Waynetown
Parker, Carl B. Wingate

MORGAN COUNTY

Alexander, Percy M. Martinsville
Bothwell, Camden G. Martinsville
Dutton, Hayes H. Martinsville
Eisenberg, David A. Martinsville
Farr, James C. Martinsville
Gray, Leon Martinsville
Grimes, Jay H. Martinsville
Pitkin, Edward M. Martinsville
Pitkin, McKendree C. Martinsville
Sweet, Austin D. Martinsville
Willan, Horace R. Martinsville
Williams, Paul D. Martinsville
Murphy, Maurice G. Morgantown
Seibel, Robert M. Morgantown
Comer, Charles W. Mooresville
Comer, Jonathan E. Mooresville
Comer, Kenneth E. Mooresville
Karpel, Bernard Mooresville
VanBokkelen, Robert W. Mooresville

Hughes, Lawrence M. Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M. Albion
Morr, John W. (H) Albion
Nash, Justin R. Albion
Sneary, Kenneth D. Avilla
Veazey, Wm. M. (H) Avilla
Ettl, Edward Cromwell
Harlan, William L. Cromwell
Bryan, Robert E. Kendallville
Goodwin, Columbus B. (H) Kendallville

Gutstein, Richard R. Kendallville
Hardy, Charles F. (H) Kendallville
Lawson, Isaac H. Kendallville
Messer, Frank W. Kendallville
Munk, Cleorie E. Kendallville
Seybert, Joseph D. Kendallville
Williams, Harold O. Kendallville
Young, Simon J. (H) Kendallville
Mettler, Don C. Ligonier
Schutt, James B. Ligonier
Stultz, Quentin F. Ligonier
Pulskamp, Bertrand H.

Wolcottville
Fair, John R. Wolf Lake
Luckey, Harold A. Wolf Lake
Lucky, Robert C. Wolf Lake
Roth, James R. Wolf Lake
Fipp, August L. Rome City
Switzer, Robert E.
Colo. Psychopathic Hosp., Denver

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, Nicholas E. French Lick
Sugarman, Benj. E. French Lick
Take, John F. (H) French Lick
Colglazier, Granville G. Leipsic
Baker, Robert E. (H) Orleans
Hodgin, Philip Orleans
Schoolfield, Wm. E. Orleans
Clark, Ivan A. Paoli
Hammond, Keith Paoli
Spears, John K. Paoli
Teaford, Schulyer F. Paoli
Boyd, Clarence E. West Baden
Miller, Henderson L. West Baden
Owens, Walter L. Manhattan, Kan.

OWEN-MONROE COUNTIES

Bloomington

Austin, Fred H. (H) 110 E. 4th St.
Baxter, Neal E. 306 E. 5th St.
Borland, Raymond M.
114 N. Lincoln St.
Buckingham, Richard E.
344 College Ave.
Culmer, Walter N.
432 S. College Ave.
Dalton, Naomi L. 114 E. 7th St.
DeMotte, Russell. 214 E. Kirkwood
Geiger, Dillon D. 300 E. Kirkwood
Hepner, Herman S. 312 N. Walnut
Holland, Charles E.
712 N. Washington St.
Holland, Deward J.
313 N. College Ave.
Holland, Philip T. 108 W. 7th St.
Karsell, William A.
306 East Kirkwood
Luzadder, John E. (H)
123½ W. 5th St.
Lyons, Robert E. 321 E. 5th St.
Marchant, Clarence H.
350 S. College
Myers, Burton D. (H)
424 N. Walnut St.
Owen, Abraham M.
200 S. Washington St.
Owen, Margaret A.
200 S. Washington St.
Prosser, William O. H.
1211 E. Maxwell Lane
Radigan, Leo R. Union Club
Ramsey, Hugh S. 107 E. 10th St.
Rhamy, Mary E. 420 S. Fess St.

OWEN-MONROE COUNTIES

(Bloomington—Continued)

Reed, William C. 307 E. 5th St.
 Rogers, Otto F., Jr.
 210 N. Washington St.
 Rogers, Robert C. (H)
 210 N. Washington St.
 Ross, Ben R. 314 E. 7th St.
 Schell, Harry D. 114 N. Lincoln St.
 Schuman, Edith B.
 Indiana University
 Smith, Herschel S.
 218 E. Kirkwood
 Smith, Rodney D. (H)
 115 N. Washington St.
 Spencer, Beaufort A.
 306 E. Kirkwood
 Stangle, Wm. J.
 Bloomington Hospital
 Topoligus, James N.
 403 N. Walnut St.
 Wilson, Talmage L.
 301 E. Kirkwood
 Wiltshire, James W. (H)
 103 S. Lincoln St.
 Yocum, Boaz (H) Coal City
 Smith, Paul E. Ellettsville
 Hazel, James T. (H) Freedom
 Stouder, Charles H. Gosport
 Mitchell, George L. Smithville
 Brown, Marcel S. Spencer
 Greene, Claude D. Spencer
 Kay, Oran E. Spencer
 Schlieker, A. G. (H) Spencer
 Smith, Frederick R. Spencer
 Hepner, Ruth P.
 Kaneohe, Oahu, T. H.

PARKE-VERMILLION
COUNTIES

Greene, Frederick G. Bloomingdale
 Brown, Ralph E. Cayuga
 Darroch, Samuel C. Cayuga
 Casebeer, Paul B. Clinton
 Evans, Frederick Clinton
 Gerrish, Wakefield D. Clinton
 Rosenfeld, Norman M. Clinton
 White, Isaac D. (H) Clinton
 Lauer, Dorothy B. Dana
 Myers, William C. Dana
 Warren, Bradford Marshall
 Britton, Welbon D. Montezuma
 Saunders, Jones L. Newport
 Johnson, William A. Perrysville
 Bloomer, Joseph R. Rockville
 Bloomer, Richard S. Rockville
 Dowell, Emil H. Rockville
 Harstad, Casper Rockville
 Merrell, Basil M. Rockville
 Pirkle, Hubert B.
 Ind. State Sanitarium, Rockville
 Staff, Robert A.
 Ind. State Sanitarium, Rockville
 White, Chester S. Rosedale
 Green, Silva Ira St. Bernice
 Keith, Freeman E. (H) St. Bernice

PERRY COUNTY

Bush, Hargis R. Cannelton
 Taylor, John E. (H) Leopold
 Coultas, Porter J. Tell City
 Dome, Hardin S. Tell City
 Dukes, David Tell City
 Glenn, Fred C. Tell City
 Hargis, Wm. T. (H) Tell City
 James, Nicholas A. Tell City

Lashley, Donald L. Tell City
 Neifert, Noel L. Tell City
 Snyder, Earl R. Troy

PIKE COUNTY

Higgins, James Lemmon Otwell
 Fowler, Richard R. Petersburg
 Kime, John T. (H) Petersburg
 Logan, Austin R. Petersburg
 Omstead, Milton Petersburg
 Rice, Thompson R. (H) Petersburg
 DeTar, George B. (H) Winslow
 Miller, Lawrence R. Winslow
 Purcell, Jack H. Winslow
 Miller, Jack B. 2399 Overlook Rd.,
 Cleveland, Ohio

PORTER COUNTY

Adair, Fred L. Chesterton
 Dale, Joseph W. Chesterton
 Griffin, Joseph P. Chesterton
 Hall, Thomas C. Chesterton
 Harless, Clarence M. Chesterton
 Butman, William C. Hebron
 Kleinman, Francis J. Hebron
 Dittmer, Samuel E. Kouts
 Brown, James C. Valparaiso
 Davis, Carl M. Valparaiso
 DeGrazia, Eugene Valparaiso
 DeWitt, Charles E. (H) Valparaiso
 Dittmer, Jack E. Valparaiso
 Douglas, Geo. R. (H) Valparaiso
 Eades, Ralph C. Valparaiso
 Frank, John R. Valparaiso
 LaRocca, Joseph Valparaiso
 Loring, Mark L. Valparaiso
 Makovsky, Theodore Valparaiso
 Miller, Ebbo H. Valparaiso
 Nash, Charles B. Valparaiso
 Powell, Edgar H. Valparaiso
 VanWinkle, Arthur J. Valparaiso
 Vietzke, Paul C. F. Valparaiso
 Gordon, Joseph L. Wheeler
 Cramp, Arthur J. (H) Box 1237,
 Hendersonville, N. C.

POSEY COUNTY

Grant, John Cynthiana
 Montgomery, Samuel B. Cynthiana
 Ropp, Harold E. New Harmony
 Thompson, Lewis R. New Harmony
 Boren, Paul Poseyville
 Boren, Samuel W. (H) Poseyville
 Woods, Arba L. Poseyville
 Challman, William B. Mt. Vernon
 Herr, John W. Mt. Vernon
 Oliphant, Frank W. Mt. Vernon
 Ranes, John R. Mt. Vernon
 Vogel, L. John Mt. Vernon
 Williams, Frederic Mt. Vernon
 Jenkinson, William E.
 Lowell Gen. Hosp., Lowell, Mass.

PULASKI COUNTY

Ives, Raymond J. Francesville
 Stover, Raymond M. Francesville
 Linton, Charles E. Medaryville
 Kelsey, Arthur J. Monterey
 Carneal, Thomas E. Winamac
 Halleck, Harold J. Winamac
 McCaskey, George H. Winamac
 Thompson, William R. Winamac

PUTNAM COUNTY

Veach, Lester W. Bainbridge
 Veach, Richard L. Bainbridge
 Gray, Clyde C. Cloverdale
 Hurst, Everett M. Cloverdale

Aker, Charles L. Greencastle
 Dettloff, Frederick Greencastle
 Dodds, O. R. Greencastle
 Fuson, Wenfred J. Greencastle
 Gillespie, Joseph F. (H)
 Greencastle

Hutcheson, Walter R. Greencastle
 Johnson, James B. Greencastle
 Nichols, Anne Sackett Greencastle
 Parker, George F. Greencastle
 Rhea, Gilbert D. Greencastle
 Schauwecker, Cleon M. Greencastle
 Steele, Dick J. Greencastle
 Tennis, George T. Greencastle
 Tipton, William R. Greencastle
 Wiseman, V. Earle Greencastle
 Gwaltney, Loral F. Roachdale
 Richards, Edgar E. Russellville

RANDOLPH COUNTY

Ahlering, George H. Farmland
 Nixon, Byron Farmland
 White, Harvey E. Farmland
 Harmon, Wayne Lyon
 Jordan, Leo E. Lynn
 Martin, Charles E. Lynn
 Slick, Crystal R. Lynn
 Shallenberger, Henry R. Modoc
 Barnard, Pliny C. (H) Parker
 Hinchman, Jean Parker
 Henderson, Arvin Ridgeville
 King, Dale S. Ridgeville
 Schenk, George H. Ridgeville
 Chambers, Leroy B. Union City
 Gullett, Charles C. Union City
 Phipps, David L. (H) Union City
 Phipps, Leland K. Union City
 Reid, Robert W. Union City
 Ruby, Fred M. Union City
 Voisinot, Raymond A. Union City
 Wills, Benjamin F. Union City
 Brenner, Andrew M. Winchester
 Brenner, Ivan E. Winchester
 Dinger, William S. Winchester
 Engle, Russell B. Winchester
 Painter, Lowell W. Winchester
 Robison, John S. Winchester
 Sparks, Paul W. Winchester

RIPLEY COUNTY

Hisrich, Lloyd W. Batesville
 Lippoldt, Charles L. Batesville
 Obery, George A. Batesville
 Conrad, Henry W. Milan
 Hunter, Lowell G. Milan
 Warn, William J. Milan
 Whitlatch, Arthur Milan
 Row, George S. Osgood
 Smith, R. Lee Osgood
 McConnell, William C. Sunman
 Hopkins, Lester H. Versailles
 Moran, Noel D. Versailles

RUSH COUNTY

McNabb, George B. Carthage
 Worth, C. Willard Milroy

Rushville

Atkins, C. C. 225 N. Morgan
 Corpe, Kenneth F. Rushville
 Dean, Donald I. 310 E. Fifth
 Denny, Melvin H. 125 W. Third
 Green, Frank, Jr. 132 E. Second
 Johnson, Robt. B. 229 N. Morgan
 Kennedy, Robt. O. 118 W. Third
 Lee, John M. 914 N. Morgan
 Nutter, W. H. 205 W. Third
 Shanks, Roy E. I.O.O.F. Bldg.

ST. JOSEPH COUNTY

Houser, D. Stanley Lakeville
 How, John T. (H) Lakeville
 How, Louis E. Lakeville

Mishawaka

Barone, C. V. 114 Lincolnway W.
 Bassler, C. R. Mishawaka Tr. Bldg.
 Christophel, Verna . . . 109 W. Third
 DuVall, W. N. . . . 117½ Lincolnway E.
 Ganser, Rich. A. . . . 203 Polis Bldg.
 Goethals, C. J. . . . 602 Lincolnway W.
 Hutchinson, B. M. . . . 117½ Lincolnway E.

Joest, Chas. O. 113 S. Church
 Logan, Francis W. . . . 208 First Nat. Bk. Bldg.

Orr, Robert. 124 S. Race
 Sirlin, Edw. M. 111 S. Church
 Spalding, Wendell L. . . 212 First Nat. Bk. Bldg.

Templeton, A. R. . . . 914 W. Lawrence
 Van Rie, Leo P. 116 S. West
 Walters, Charles. . . . 206 Polis Bldg.
 Ward, Jas. W. 316 Lincolnway E.
 Whitlock, Merle E. . . 123 W. Fourth
 Wixted, Jno. F. . . . 114 Lincolnway W.
 Wixted, Julia F. . . . 114 Lincolnway W.

Wurster, Herbert C. . . 221 E. Third
 Wygant, Marion D. . . 116 W. Third
 Wyland, Byron J. . . . 116 W. Third
 Zimmer, H. J. . . . 119½ Lincolnway W.
 Luzadder, John E., Jr. New Carlisle
 Hardy, John J. North Liberty
 Warrick, Homer Lyle . . . Osceola

South Bend

Abel, Joseph A. . . . 1222 Western Ave.
 Acker, Robert B. . . . 418 Sherland Bldg.

Arisman, Ralph K. . . . 711 Odd Fellow Bldg.
 Balla, Morris 404 Sherland Bldg.

Bartsch, Harvey L. . . . 1909 S. Michigan St.
 Bechtold, Samuel E. . . 730 J.M.S. Bldg.

Bennett, Jene R. . . . 531 Main St.
 Berke, Robert D. . . 1721 East Ewing
 Biasini, Benedict A. . . 401 Dixie Way North

Bickel, David A. . . . 515 Odd Fellows Bldg.
 Birmingham, Peter J. . 426 Sherland Bldg.

Bishop, Charles A. . . 120 N. Lafayette Blvd.
 Bixler, Louis C. . . . 615 Sherland Bldg.

Blackburn, Erwin . . . 508 Sherland Bldg.
 Bodnar, Leslie M. . . . 215 Poledon Bldg.

Bolka, Bernard 728 W. Colfax
 Borough, L. D. . . . 514 J.M.S. Bldg.

Braunsdorf, Robert L. . 514 Sherland Bldg.
 Bryan, Robert J. . . . 1002 Lincolnway W.

Buchanan, Wallace D. . 825 Sherland Bldg.
 Buechner, Frederick W. . 116 N. Main St.

Bussard, Clifford F. . . 634 Associates Bldg.
 Bussard, Frank 634 Associates Bldg.

Carter, F. R. N. . . . 605 Sherland Bldg.
 Cassady, James V. . . . 525 Sherland Bldg.

Caton, Joseph R. . . . 1123 Niles Ave.
 Chambers, William . . . 822 Sherland Bldg.

Clapp, Fred R. 120 N. Lafayette Blvd.
 Clark, Stanley A. . . . 1242 E. Jefferson St.

Clark, William H. . . . 120 N. Lafayette Blvd.
 Colip, George D. . . . 410 Sherland Bldg.

Condit, David H. . . . 120 N. Lafayette Blvd.
 Cook, Gordon C. . . . 120 N. Lafayette Blvd.

Cooper, Harry L. . . . 410 Sherland Bldg.
 Culbertson, Carl S. . . 531 N. Main St.

Cunningham, R. D. . . 604 N. Main St.
 Custer, Edward W. . . . Healthwin Sanitarium

Denham, Robert H. . . . 425 Odd Fellows Bldg.
 Dietl, Ernest L. . . . 527 Sherland Bldg.

Donnelly, Everett F. . . 730 W. Indiana Ave.
 Dodd, Robert D. . . . 759 Portage Ave.

Duggan, James A. . . . 316 St. Joseph Bank Bldg.
 Dunlap, D. Logan . . . 409 J.M.S. Bldg.

Edwards, Bernard E. . . 226 Sherland Bldg.
 Egan, Sherman 628 Sherland Bldg.

Ellison, Alfred 826 Sherland Bldg.
 English, John P. . . . 120 N. Lafayette Blvd.

Ericksen, Lester G. . . 615 Sherland Bldg.
 Faltin, Ladislaus . . . 609 Odd Fellows Bldg.

Feldman, Max 1921 Miami St.
 Filipek, Walter J. . . . 311 Odd Fellows Bldg.

Firestein, Ben Z. . . . 521 J.M.S. Bldg.
 Firestein, Ray 3201 Mishawaka Ave.

Fish, Clyde M. . . . 723 Sherland Bldg.
 Fish, Edson C. . . . 401 N. Notre Dame Ave.

Fisher, Lawrence F. . . 825 Sherland Bldg.
 Frank, Lyall L. . . . 224 W. Navarre

Frash, DeVon W. . . . 1910 Miami St.
 Friedman, Morris S. . . 218 Poledor Bldg.

Frith, Gladys 521 W. Washington Ave.
 Frith, Louis G. . . . 521 W. Washington Ave.

Frost, Robert J. . . . 531 N. Main St.
 Gates, George E. . . . 120 N. Lafayette Blvd.

Gilman, Marcus M. . . . 403 Odd Fellow Bldg.
 Giordano, Alfred S. . . 531 N. Main St.

Goraczewski, Thaddeus C. 1016 W. Washington Ave.
 Gordon, J. M. 726 J.M.S. Bldg.

Green, G. F. 822 Sherland Bldg.
 Green, Norval E. . . . Poledor Bldg.

Grillo, Donald 530 Sherland Bldg.
 Haley, Paul E. . . . 401 Sherland Bldg.

Hamilton, Chas. D. . . 814 Turnock
 Harmon, V. E. . . . 302 Sherland Bldg.

Helmen, H. W. . . . 120 Franklin Place
 Hewitt, M. I. . . . 315 Sherland Bldg.

Hilbert, J. W. . . . 410 W. Washington
 Hillman, M. W. . . . 429 Sherland Bldg.

Hillman, W. H. . . . 429 Sherland Bldg.
 Hoffman, R. V. . . . 416 Sherland Bldg.

Holdeman, L. S. . . . 404 N. Lafayette
 Holdeman, R. W. . . . 404 N. Lafayette

Huffman, A. D. . . . 718 Sherland Bldg.
 Hyde, C. C. 120 N. Lafayette

Kamm, B. A. 526 Sherland Bldg.
 Karn, John 728 W. Colfax Ave.

Klahr, E. E. . . . 706 Odd Fellow Bldg.
 Knapp, Arthur L. . . . 2215 Mishawaka

Knode, K. T. 729 Sherland Bldg.
 Kramer, Albert A. . . . 1519 Miami

Kuhn, F. L. 1215 S. Michigan
 Lane, William H. . . . 604 N. Main

Lang, Joseph E. . . . 730 J.M.S. Bldg.
 Langenbahn, Carl J. . . 206 Sherland Bldg.

Lionberger, John R. . . 615 Sherland Bldg.
 Liss, E. C. 317 Odd Fellow Bldg.

Ludwick, H. 2730 Lincolnway W.
 Luthy, Karl R. . . . 505 N. St. Joseph

Mason, Bernard A. . . . 120 N. Lafayette Blvd.
 McCraley, W. J. . . . 406 Sherland Bldg.

McDonald, R. M. . . . 410 J.M.S. Bldg.
 McFarland, Corley B. . 120 N. Lafayette Blvd.

McKenna, H. J. . . . 1615 E. Wayne
 McMeel, J. E. . . . 612 Associates Bldg.

Metcalfe, Grant E. . . . 319 Odd Fellow Bldg.
 Mikesch, W. H. . . . 816 Sherland Bldg.

Miller, Milo K. 120 N. Lafayette Blvd.
 Miller, W. E. 714 W. Washington

Mott, C. A. 1301½ W. Washington
 Murphy, Eugene C. . . . 120 N. Lafayette Blvd.

Murphy, J. F. 625 J.M.S. Bldg.
 Nelson, F. Dale 428 Sherland Bldg.

Nelson, R. E. 510 Sherland Bldg.
 Olney, T. A. (H) . . . Country Club Rd.

Olson, K. L. 615 Sherland Bldg.
 Parke, D. Davis . . . St. Joseph Hosp.

Pauszek, T. B. . . . 726 W. Washington
 Petrass, A. 516 Sherland Bldg.

Plain, G. 120 N. Lafayette Blvd.
 Proudfit, Charles H. . . 525 Odd Fellow Bldg.

Pyle, H. D. 518 Sherland Bldg.
 Rasmussen, Ruth F. . . 120 N. Lafayette Blvd.

Rigley, E. L. 408 Sherland Bldg.
 Rodin, H. H. 422 Sherland Bldg.

Rosenheimer, G. M. . . 604 N. Main
 Rubens, Eli 201 Christman Bldg.

Rudolph, Carl J. . . . 617 J.M.S. Bldg.
 Sanderson, Robert B. . 730 Sherland Bldg.

Sandock, L. 402 Sherland Bldg.
 Sandock, Louis F. . . . 406 Platt Bldg.

Sandoz, Harry H. . . . 615 Odd Fellows Bldg.
 Sandoz, L. A. 720 Sherland Bldg.

Savery, C. E. 230 Sherland Bldg.
 Schiller, H. A. . . . 510 Sherland Bldg.

Scott, F. M. 120 N. Lafayette Blvd.
 Selby, Keith E. . . . 407 Lincolnway W.

Sennett, C. M. . . . 318 Sherland Bldg.
 Sensenich, R. L. . . . 203 J.M.S. Bldg.

Sensenich, R. L. . . . 203 J.M.S. Bldg.
 Seyler, Paul G. . . . 810 S. Illinois

Shelly, Edward . . . 302 Sherland Bldg.
 Skillern, P. G. . . . 1002 Bldg. & Ln. Tr.

ST. JOSEPH COUNTY

(South Bend—Continued)

Slominski, Harry H.
708 Odd Fellow Bldg.
Spenner, R. W. 726 Sherland Bldg.
Staunton, H. A. 3023½ Mishawaka
Stiver, D. D. 528 Sherland Bldg.
Thompson, John M.
527 Sherland Bldg.
Thornton, M. J. 825 Sherland Bldg.
Traver, P. C. 1010 Riverside Dr.
Wegner, W. C. (H) 616 W. Wash.
Weiss, Eugene 2521 S. Michigan
Wilhelm, A. M. 628 Sherland Bldg.
Wilson, James 611 J.M.S. Bldg.
Linton, Charles D. Walkerton
Cline, Kenneth L. Wyatt
Libnoch, Casimir L. 2965 Lawndale,
Chicago, Illinois
Rosenwasser, J. 84 Fenway, Apt. 3,
Boston, Mass.

SCOTT COUNTY

Bogardus, Carl R. Austin
Hill, Thomas N. Scottsburg
McClain, Marvin L. Scottsburg
Napper, Floyd S. Scottsburg

SHELBY COUNTY

Nigh, Rufus M. Fairland
Davis, John A. Flat Rock
Nave, H. E. Fountaintown
Patten, Vernon C. (H) Morristown

Shelbyville

Billman, Gustus S. R. 2
Coomes, M. Joseph (H) Shelbyville
Gehres, Robert W. 15 S. Tompkins
Inlow, H. H. 103 W. Washington
Inlow, W. D. 103 W. Washington
Miller, Richard C. 17 Mechanic
Richard, N. F. 103 W. Washington
Scott, C. C. 103 W. Washington
Scott, V. B. 103 W. Washington
Tindall, Paul R. 20 N. Pike
Tindall, W. R. 505 S. Harrison
Whitcomb, Roger F.
302 Methodist Bldg.
Wiley, William M. Shelbyville
Coulson, Sewell B. Waldron

SPENCER COUNTY

Springstun, Charles L. Chrisney
Barrows, John H. Dale
Medcalf, Norman L. Lamar
Jolly, Parvin W. Richland
Atchison, Kenneth C. Rockport
Buxton, Eva J. (H) Rockport
Ehrman, Calder D. Rockport
Glackman, John C., Jr. Rockport
Westerbeck, C. W. St. Meinrad

STARKE COUNTY

DeNaut, James L. Hamlet
Ferguson, John T. Hamlet
DeNaut, James F. Knox
Henry, Howard S. Knox
Ingwell, Guy B. Knox
Farabee, Charles R. North Judson
Matthew, J. R. North Judson

STEUBEN COUNTY

Barton, Robert Angola
Creel, Donald W. Angola
Crum, Marion M. Angola
Kissinger, Knight L. Angola
Lane, William H. (H) Angola
Mason, Donald G. Angola
Rausch, Norman W. Angola
Blosser, Blaine A. Fremont
Alford, James Hamilton
Denman, Robert D. Helmer

SULLIVAN COUNTY

Brown, John S. Carlisle
Whipps, Charles E. Carlisle
Dukes, Betty Dugger
Dukes, Frederic M. Dugger
Dukes, Joe E. Dugger
Bland, Herbert E. (H) Fairbanks
Butler, John O. Farmersburg
O'Dell, Harry C. Farmersburg
Oliphant, Jacob T. Farmersburg
Hamilton, Antha Ann Shelburn
Bedwell, Marion H. Sullivan
Briggs, Carl F. Sullivan
Crowder, James H. Jr. Sullivan
Higbee, Paul Sullivan
Maple, James B. Sullivan
Scott, Garland D. Sullivan
Scott, Irvin H. Sullivan
Donnelley, Robert W.

Arabian American Oil Co. Hosp.,
Dhahran, Arabia
O'Dell, Harry W. Philadelphia, Pa.

SWITZERLAND COUNTY

Bear, Lowery H. (H) Vevay
Copeland, Geo. W. (H) Vevay
Ellerbrook, George E. Vevay
Zink, Robert O. Vevay
Bakes, Fred C.
1055 N. Kingsley Dr.,
Los Angeles, Calif.

TIPPECANOE COUNTY

Wagoner, Robert H. Colburn

Lafayette

Ade, C. H. Lafayette Life Bldg.
Ade, Mary K. Lafayette Life Bldg.
Arnett, Arett C. 312 N. Eighth
Balkema, C. M. 31 N. Twentieth
Bauer, Arthur J. 112 N. Seventh
Bayley, R. H. M. 312 N. Eighth
Bayley, William E. Home Hospital
Buhrmester, Harry C. Jr.
312 N. Eighth

Burkle, John C. 133 N. Fourth
Calvert, Raymond R. 314 N. Sixth
Cole, Ira 2315 South
Coloviras, George Sr.

St. Elizabeth's Hospital
Cox, Wayne T. 206-7 Schultz Bldg.
Coyner, Alfred B.

815-16 Lafayette Life Bldg.
Crockett, Franklin S.

724 Lafayette Life Bldg.
Currie, R. W. St. Elizabeth's Hosp.
Dewey, G. W. (H) Soldiers Home
Donahue, George R.

Lafayette Life Bldg.

Dubois, Ramon B. 516 Main
Eaton, M. J. Lafayette Life Bldg.
Engeler, James E. 308 N. Eighth
Ferguson, Wm. B. 24 N. 24th St.
Flack, Russell A. 217 N. Sixth
Frasch, M. G. Lafayette Life Bldg.
Gery, Richard E. 312 N. Eighth

Graham, T. G. 11 N. Twenty-fourth
Harshman, M. L. 312 N. Eighth
Harter, Eli Blair 312 N. Eighth
Herrold, George W.

Lafayette Life Bldg.

Holladay, Lloyd J. Lafayette Life Bldg.

Lafayette Life Bldg.

Hunter, F. P. Lafayette Life Bldg.

Hupe, Charles (H) 212 N. Eighth

Ikins, Ray G. 605 S. Seventh

Jones, David 24 N. Twenty-fourth

Johnson, Lowell R. 2315 South

Karberg, R. J. 15 N. Twenty-fifth

Klepinger, Harry E.

824 Lafayette Life Bldg.

Laws, H. J. Lafayette Life Bldg.

Laws, Kenneth F.

501 Lafayette Life Bldg.

Leak, R. H. St. Elizabeth's Hosp.

Levering, Guy P. 819 Central

Loop, Floyd A.

Lafayette Life Bldg.

Loop, F. A. Lafayette Life Bldg.

Lynch, O. R. Wabash Valley San.

McAdams, H. B. 1411 Sunset Dr.

McClelland, D. C. 312 N. Eighth

McFadden, James M.

St. Elizabeth's Hosp.

McKinney, Daniel H.

Lafayette Life Bldg.

Marsh, G. W. 1405 N. Fourteenth

Martin, Harold G. 417 Ferry

Martin, Harold R. 417 Ferry

Martin, Joe M. 417 Ferry

Miller, Roland E. 1625 Kossuth

Morrison, John S. (H)

Lafayette Life Bldg.

Neumann, Kenneth O.

613 Lafayette Life Bldg.

Pearlman, Samuel S. 107 N. Sixth

Peterson, Joel A.

609 Lafayette Life Bldg.

Peyton, Frank W. 15 N. 25th

Ratcliff, Frank W. 300 Main

Romberger, Floyd T.

405 Lafayette Life Bldg.

Rothrock, Philip W. 1625 Kossuth

Ruschli, Edward B.

Lafayette Life Bldg.

Shafer, John W. 619 Kossuth

Sholty, William M.

405 Lafayette Life Bldg.

Smith, Lowell C. 405 Schultz Bldg.

Stahl, Edward T. 312 N. Eighth

Stoen, Harold J.

Lafayette Life Bldg.

Strayer, Joseph W.

612 Lafayette Life Bldg.

Strickland, Martha B. 319 N. 26th

Thomas, Gordon A. 608 Columbia

Trout, Carl J. 314 N. Sixth

Tubbs, George R. 608 Columbia

VanBuskirk, E. L. 308 N. Eighth

Waite, Richard R. 115 S. Sixth

Washburn, Will W. 312 N. Eighth

Mitchell, Edgar T. Romney

Babb, Forrest J. Stockwell

West Lafayette

Ash, Harold H. 225 State

Hillsmer, Phyllis Purdue Univ.

Meikle, Louise J. 606 Ferry Lane

Miller, Sayers J. Purdue Univ.

Rommel, C. H. 460 Northwestern

Rose, Bertha Purdue Univ.

Smith, Marsh H. Purdue Univ.

Spurlock, Fae H. 214 Northwestern

Youman, Tom Fort Jackson,

North Carolina

TIPTON COUNTY

Cotton, Stanley M. Goldsmith
 Kunham, Wilbur F. Kempton
 Stouder, Albert E. Kempton
 Tranter, William F. Sharpsville
 Burkhardt, Boyd A. Tipton
 Carter, Jean V. Tipton
 Compton, George Tipton
 Gossard, Meredith B. Tipton
 Kurtz, William A. Tipton
 Overman, Frederick V. Tipton
 Warne, George H. Tipton
 Ericson, Harold L. Windfall
 Moser, Elmer B. Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY
 Evansville

Acre, Robert R. 617 Hulman Bldg.
 Adler, Raymond N. 714 Second
 Alexander, John E. 609 Hulman Bldg.
 Anderson, Dwight W. 814 N. Main
 Antes, Earl H. 412 SE Fourth
 Austin, E. W. 216 SE Riverside Dr.
 Baker, C. S. 1931 E. Powell
 Baker, H. M. 402 Hulman Bldg.
 Baker, Jas. S. 407 Metro Bk. Bldg.
 Barclay, Irvin C. 114 SE Second
 Barnhart, Willard T. 527 Sycamore
 Baylor, Edward M. 415 S. Lincoln
 Beeler, Bruce H. 301 Third & Main Bldg.

Bennett, Abner

Welborn Baptist Hosp.

Boswell, R. W. C. 2005 W. Franklin
 Boyd, Stella N. B. 502 Hulman Bldg.

Brockmole, A. W. 700 Mary St.
 Brown, J. A., Jr. 605 E. Sixth
 Brown, Robt. L. 629½ Main
 Browne, W. A. Court Hse. Annex
 Bryan, S. L. 902 Hulman Bldg.
 Buchholz, R. R. 412 SE Fourth
 Buikstra, C. R. 609 Hulman Bldg.
 Burnikel, Ray H. 221 Chestnut
 Cacia, John J. 609 Hulman Bldg.
 Caldwell, W. C. 504 Old Nat. Bk.
 Clements, Albert F. 15 SE Second
 Clouse, Paul A. 642 Benninghof
 Cockrum, W. M. 908 Hulman Bldg.
 Cody, Burtis L. 204 Boehne Bldg.
 Cole, William L. 1338 Division
 Coleman, W. H. 322 N. Fulton
 Combs, H. T. 807 W. Indiana
 Combs, Jno. H. 412 S.E. Fourth
 Combs, Pearl B. 1623 Lincoln
 Conover, Earl 1930 Bayard Pk. Dr.
 Corcoran, P. J. V. 118 S. First
 Crawford, Jas. H. 221 Chestnut
 Crevello, Albert J.

Clearview Hosp., Kratzville Rd.
 Crimm, Paul D. Boehne Hosp.
 Cullnane, C. W. 2312 W. Franklin
 Daves, William L. 608 Old Nat. Bk. Bldg.

Davidson, William D. 308 Am. Tr. Bldg.

Davidson, W. R. 308 Am. Tr. Bldg.
 Denzer, Edw. K. 108 SE Second
 Denzer, Wm. O. 108 SE Second
 Dieckman, H. S. 1012 Cit. Bk. Bldg.
 Diefendorf, Charles F. 2106B W. Franklin

Dodd, Roberts K. 819 W. Franklin
 Durkee, Melvin S. 403 Citizens Nat. Bk. Bldg.

Dycus, Walter A. 2200 W. Franklin
 Dyer, W. K. 910 Hulman Bldg.

Ehrich, William S. 808 Old Nat. Bk. Bldg.

Eisterhold, J. A. 220 SE Riverside
 Engel, Edgar L. 15 SE Seventh
 Faul, Henry J. 815 Hulman Bldg.
 Fickas, Dallas 619 Mary St.
 Fisher, Wm. C. 413 First Ave.
 Fitzsimmons, E. L. 527 Sycamore
 Flinn, J. H. 420 Hulman Bldg.
 Folz, Charles J. 2A SE Fifth
 French, Wm. G. Sta. D, Box 2006
 Friedman, Leo 9 Main
 Fritsch, Louis E. 1201 First
 Garland, Edgar A. 606 S. Weinbach
 Gaul, L. Edw. 509 Hulman Bldg.
 Gill, Bernard P. 113½ NW Fifth
 Goux, Warren St. Mary's Hosp.
 Griep, Arthur H. 412 SE Fourth
 Grosskreutz, Doris 705½ Main
 Hare, Daniel M. 617 Hulman Bldg.
 Hare, John H. Evansville St. Hosp.
 Harris, Wm. Lee 115 S. E. 6th St.
 Hart, L. Paul 207 SE First
 Hartley, C. A., Jr. 221 Chestnut
 Hartley, C. A., Sr. (H) 417 Peoples Sav. Bk. Bldg.

Hartz, F. Minton 123 SE Second
 Healy, Wm. F. 607 Hulman Bldg.
 Heard, Albert 322 E. Cherry
 Heberer, Jos. M. 1111 W. Columbia
 Hefti, Karl R. 125 SE Second
 Heinrich, Weston A. 1308 N. Main
 Helper, Morton 219 Walnut
 Herzer, Clarence C. 322 N. Fulton
 Hobbs, Arthur Protestant Deaconess Hosp.

Hoopes, Jane M. 125 SE Second
 Hornaday, W. A. 2033 Bellemeade
 Huggins, Victor S. 601 Citizens Nat. Bk. Bldg.

Hyatt, Gilbert T. 412 SE Fourth
 Johnson, G. C. (H) 212 Am. Tr. Bldg.

Johnson, Stephen L. 521 Sycamore
 Kauffman, H. M. 219 Walnut St.
 Kerrigan, Wm. F. St. Mary's Hosp.
 Kessler, Robt. B. 1003 First Ave.
 Kiechle, F. L. Boehne Hosp.
 King, Everett A. 208½ Main
 Kirch, Leo N. 912 Hulman Bldg.
 Kleindorfer, R. L. 819 W. Franklin
 Lang, Shirley C. 957 S. Kentucky
 Laubscher, Clarence Kratzville Rd.
 Lawrence, Jos. C. 415 First Ave.
 Leich, Chas. F. 124 SE First
 Leslie, Ernil T. 122 Locust
 Logan, Jesse R. 503 First Ave.
 Lynch, Harold D. 216 SE Riverside
 Lynch, Paul V. 216 SE Riverside
 McCool, Joe H. 1308 N. Main
 McCool, William E. (H) R. 12, Camp Ground Rd.

McDonald, Jos. D. 527 Sycamore
 Macer, C. G. 411 Hulman Bldg.
 MacKenzie, Pierce 15 SE Seventh
 Mason, E. E. 906 Hulman Bldg.
 Mehl, Rudolph A. 752 S. Eighth
 Meyer, Keith T. 118 SE First
 Miller, Laverne B. 714 N. Main
 Miller, Milton 103 N. Main
 Miller, Minor Court Hse. Annex
 Miller, Robert J. 1905 Division
 Mills, Fred E. Deaconess Hosp.
 Mino, Victor H. 723 Mary
 Moehlenkamp, Charles E. 614 N. Governor

Muelchi, A. F. 518 Hulman Bldg.
 Nenneker, Henry (H) Harmonyway

Neucks, H. C. 303 Chandler Ave.
 Newman, A. E. 912 Hulman Bldg.
 Niedermayer, Alfred J. Welborn Baptist Mem. Hosp.

Nisenbaum, Harold 704 Hulman Bldg.

Oppenheimer, Ernst 103 SE Second
 Pollard, Walter S. 115 SE Second
 Present, Julian 6 SE Second
 Pugh, Willis 413 First
 Raphael, I. J. 617 Hulman Bldg.
 Ratcliffe, A. W. 510 S. E. First
 Ravdin, B. D. 712 Hulman Bldg.
 Ravdin, M. (H) 712 Hulman Bldg.
 Reich, Clarence E. 1209 N. Fulton
 Reitz, Thos. F. 700 N. Sixth
 Richey, Clifford O. 783 Washington
 Rininger, H. C. 1359 Washington
 Ritz, Albert S. 2605 Lincoln
 Robinson, Earl U. 615 Bellemeade
 Rosenblatt, B. B. 709 Hulman Bldg.
 Rosso, Russell J. 118 SE First
 Royster, G. M. 810 Cit. Bk. Bldg.
 Royster, R. A. 810 Cit. Bk. Bldg.
 Ruddick, H. C. 816 Hulman Bldg.
 Rusche, Henry J. 701 Harriet
 Schirmer, R. H. 1118 W. Franklin
 Schneider, Charles P. W. Franklin
 Schrieffer, Victor V. 1307 Stringtown Rd.

Slaughter, John 808 Cit. Bk. Bldg.
 Slaughter, H. C. 908 Hulman Bldg.
 Slaughter, O. L. 118 E. First
 Snively, W. D., Jr. Mead Johnson & Co.

Springstun, Walter R. 601 Hulman Bldg.

Stork, Urban 412 SE Fourth
 Sterne, John Evansville
 Sutter, Chas. C. 1311 Cumberland
 Taylor, Eugene C. 853 Lincoln
 Tilden, Margaret H. St. Mary's Hosp.

Tweedall, D. C. 2202 W. Illinois
 Tweedall, D. G. 2114 W. Franklin
 Underwood, Gordon B. 509 Hulman Bldg.

Viehe, Robt. W. 207 SE First
 Visser, J. S. 805 Old Nat. Bk. Bldg.
 Visser, John W. 805 Old Nat. Bk. Bldg.

Weber, Edgar H. 123 SE Second
 Weiss, Henry G. 614 Hulman Bldg.
 Welborn, Mell B. 412 SE Fourth
 Wesson, Thos. W. 124 SE First
 Wilhelmus, Charles K. 114 SE 6th St.

Wilhelmus, Gilbert 1650 E. Walnut
 Wilhelmus, Wm. M. R. R. 7
 Willis, Chas. F. 1100 S. Bedford
 Willison, G. W. 118 SE First
 Wilson, J. D. 1207 E. Park Dr.
 Wilson, Ralph 517 Mary
 Wishart, Shelby W. 416 3rd & Main Bldg.

Wood, Wm. H. 1651½ Lincoln Av.
 Woods, Wm. P. 15 SE Seventh
 Wynn, J. F. 906 Hulman Bldg.
 Yeck, Charles W. 115 SE Sixth
 Yunker, Philip E. 116 Mulberry
 Zimmerman, Harold 6 SE Second
 Coffman, Delmer Lee Western Okla. T. B. Hosp.,
 Clinton, Okla.

Scales, Alfred B. Pickston, South Dakota

Wyatt, Fred H. 644 Glencoe St.,
 Denver, Colo.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B. New Goshen
McIntosh, Wilbert. Riley
Carmichael, Clyde S. Seelyville
Terre Haute
Agee, Ernest B., Jr. 221 S. Sixth
Alexander, Oliver O.

301 Rose Disp. Bldg.
Allen, O. T. 422 Rose Disp. Bldg.
Anderson, W. C. 721 Wabash
Asbury, W. D. 322 Rose Disp. Bldg.
Ault, Roy, Jr. Tribune Bldg.
Baldridge, William O.

12 Points State Bk. Bldg.
Bernheimer, H. L. (H) 506 Ohio
Blum, Leon L. 721 Wabash
Bopp, Henry W.

521 Grand Opera Hse. Bldg.
Bopp, James. 521 Opera Bldg.
Bradley, Stephen C. 221 S. Sixth
Bronson, Paul J. 721 Wabash
Brown, Robert R. 221 S. Sixth
Cabell, A. L. (H) 16 White Bldg.
Cajacob, Melville E. 1000 S. Sixth
Carpenter, George C. 410 Ohio
Cavins, Alexander W. 221 S. Sixth
Combs, Chas. N. 2516 N. Ninth
Combs, S. R. 505 Tribune Bldg.
Congleton, Geo. C.

308 Merchants Nat. Bk. Bldg.
Conklin, J. O. 500 Rose Disp. Bldg.
Connelly, Jno. J. Rose Disp. Bldg.
Crawford, Wm. G. 221 S. Sixth
Curry, C. A. 506 Rose Disp. Bldg.
Dailey, John E. 1230 Wabash
Decker, Harvey B. 202 Rea Bldg.
Dorsey, Philip W. Tribune Bldg.
Dyer, Geo. W. 208 Rose Disp. Bldg.
Edmondson, R. E. 2201 S. Center
Eisenlohr, Eugen 100 S. Sixth
Forsyth, David H.

215 Merchants Nat. Bk. Bldg.
Freed, J. E. 414 Rose Disp. Bldg.
Fuqua, H. B. Rose Disp. Bldg.
Gerrish, D. A. Rose Disp. Bldg.
Gilbert, Ivan 505 Rose Disp. Bldg.
Gillum, John R. 221 S. Sixth
Goodman, Hubert T.

310 Opera House Bldg.
Harkness, Robert G.

301 Rose Disp. Bldg.
Haslem, E. R. 401 Rose Disp. Bldg.
Haslem, John R. 221 S. Sixth
Hoover, Dewey A. 14½ N. Third
Hoover, Jas. J. 14½ N. Third
Humphrey, Paul E.

322 Rose Disp. Bldg.
Hunt, Edgar J. R. R. 1
Johnson, Paul D. 822 N. 15th
Kabel, Robert N. Tribune Bldg.
Kreible, William W. 221 S. Sixth
Kunkler, Joseph 408 Chestnut
Kunkler, William C.

212 Merchants Bk. Bldg.
LaBier, Clarence Rollin (H)

408 Rose Disp. Bldg.
LaBier, C. R. 408 Rose Disp. Bldg.
Lancet, Robert O. 2022 Wabash
Lee, Allen H. 502 Tribune Bldg.
Loewenstein, W. L. 1421 S. Seventh
Love, John R. 1601 Eighth Ave.
Lukett, C. L. 211 Fairbanks Bldg.
McBride, Noel S.

407 Merchants Nat. Bk. Bldg.

McCarthy, Frank G. 721 Wabash
McCormick, Wilbur C.

312 Merchants Bk. Bldg.
McEwen, James W.

321 Rose Disp. Bldg.

McLaughlin, Gordon C.
501 Tribune Bldg.

Mahoney, Charles L. 221 S. Sixth

Malone, Leander A. 721 Wabash

Mason, Lester M.

312 Merchants Nat. Bk. Bldg.

Mattox, Don M. 721 Wabash

Meyn, Werner P. 221 S. Sixth

Miklozek, John E. 1461 S. Seventh

Miller, Daniel B. 1603 S. Seventh

Mitchell, A. M. 503 Tribune Bldg.

Mohr, Ann L. M. R. R. 1,

West Terre Haute

Musselman, G. G. 2257 Fifth Ave.

Nay, Ernest O. 221 S. Sixth

Oliphant, R. W. 410 Tribune Bldg.

Pearce, Roy V. 523 N. Seventh

Pierce, Harold J. 627 Cherry

Rarick, Alden J. 627 Cherry

Reynolds, Richard J. 901 S. 25th

Richart, J. V. 414 Rose Disp. Bldg.

Riggs, Floyd C.

Indiana State Teachers College

Rubin, Milton M. Tribune Bldg.

Sayers, F. E. 507 Rose Disp. Bldg.

Scherb, Burton E. 104 N. Seventh

Schott, Edward J.

Merchants Nat. Bk. Bldg.

Schumaker, Robert A.

211 Fairbanks Bldg.

Selsam, Etta

203 Merchants Nat. Bk. Bldg.

Shanklin, Vernon A.

208 Fairbanks Bldg.

Showalter, J. R. 1255½ Maple Rd.

Siebenmorgen, L. 1200 S. Eighth

Siebenmorgen, P. 1200 S. Eighth

Silverman, N. M. 1634 S. Seventh

Sloss, Imit H. 1029 S. Seventh

Smoots, S. A. 1307 Maple Ave.

Spears, R. C. 402 Tribune Bldg.

Spigler, James F.

314 Merchants Nat. Bk. Bldg.

Stewart, Walter E. 721 Wabash

Stoelting, J. L. 204 Fairbanks Bldg.

Strong, Daniel S. R. R. 7, Box 170

Sullivan, John M. 907 College

Topping, M. C. 505 Tribune Bldg.

Utterback, Arnold

603 Merchants Nat. Bk. Bldg.

VanArsdall, C. R. 17 S. Ninth

Vandivier, Henry R.

210 Rose Disp. Bldg.

Voges, Edward C. 1402 Wabash

Warren, Ward 221 S. Sixth

Weber, Joseph G. S. 721 Wabash

Weinstein, Joseph H. 221 S. Sixth

White, Jas. V. Tribune Bldg.

Wiedemann, Frank E. (H)

222 Rose Disp. Bldg.

Wilkerson, Edw. L. 6½ N. Fourth

Wilson, Fred L. 1501 S. Third

Wyeth, Chas. (H) 1100 S. Seventh

Yung, J. R. 501 Rose Disp. Bldg.

Zwerner, Paul F.

12 Points State Bk. Bldg.

Beck, Robert A.

Flat Rock Co., Mont.

Day, Theodore P. 832 Waverly Rd.,

Willoughby, Ohio

Freed, John E., Jr.

Wesley Memorial Hosp.,
Chicago, Ill.

Niblack, Earl S. (H)

136 N. Woods Rd.
Manhasset, New York

WABASH COUNTY

Walker, James L. LaFontaine
Balsbaugh, Geo. N. Manchester
Brubaker, O. G. N. Manchester
Bunker, L. Z. N. Manchester
Cook, Chas. E. N. Manchester
Seward, Geo. W. N. Manchester
Venable, Geo. L. N. Manchester
Warvel, Jos. L. (H) N. Manchester
Kidd, James G. Roann
Black, Edgar K. Wabash
Dannacher, Wm. D. Wabash
LaSalle, Robert M. Wabash
Mills, John F. Wabash
Naugle, Raymond A. Wabash
Pearson, William E. Wabash
Rhamy, Arthur P. Wabash
Steffen, Arthur J. Wabash
Steffen, Julius T. Wabash
Stoops, Jean T. Wabash
Wall, Joseph A. Wabash
Whisler, Frederick M. Wabash
Thompson, Noah H. (H)

Bedford, Va.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Faith, I. L. Boonville
Hoover, J. Guy Boonville
Hoover, Peter B. Boonville
Stover, Wendell C. Boonville
Wilson, Paul E. Boonville
Taylor, Lon S. Elberfeld
Wilhelmus, Charles M. Newburgh
Zwickel, Ralph E. Newburgh
Springstun, Charles E. Tennyson

WASHINGTON COUNTY

Tower, Thomas K. Campbellsburg
Green, William L. Pekin
Allen, Fred K. Salem
Episcopo, A. R. Salem
Gilliatt, James P. Salem
Huckleberry, Irvin E. Salem
Mitchell, John I. Salem
Paynter, Lawrence W. (H) Salem
Mull, Philip L. (H)

Box 1432, Louisville, Ky.

WAYNE-UNION COUNTIES

Clark, Marion E. Cambridge City
Hill, Paul G. Cambridge City
Kenyon, Charles E. Cambridge City
Barton, Willoughby M. Centerville
Bartlett, Robert C. Dublin
McKee, Charles E. (H) Dublin
Marsh, Chester A. Hagerstown
Miller, William A. Hagerstown
DuBois, Franklin T. (H) Liberty
Lewis, James F. Liberty
McWilliams, William B. Liberty
Thompson, Will A. Liberty

Richmond

Ake, Loren

410 First Nat. Bk. Bldg.

WAYNE-UNION COUNTIES

(Richmond—Continued)

Allen, Hubert E. 21 S. Eighth
 Ballenger, William E.
 309 Med. Arts Bldg.
 Blossom, Paul W. 825 S. A St.
 Bond, Charles S. (H) . . . 112 N. Tenth
 Buche, Fredk. P. 106 S. Seventh
 Campbell, Perry A.
 422 Med. Arts Bldg.
 Coble, Frank H. 51 S. Eighth
 Cook, Norman R.
 508 First Nat. Bk. Bldg.
 Cox, Leon T. 36 S. Eighth
 Denny, Edgar C. Rich. St. Hosp.
 Dingle, P. E. 403 Med. Arts Bldg.
 Erk, Vernon 717 S. Seventh
 Ewbank, J. Nelson
 Smith-Esteb Hosp.
 Faulkner, Wm. H. 29 S. 12th
 Griffis, V. C. 208 Med. Arts Bldg.
 Hadley, Harvey
 First Nat. Bk. Bldg.
 Hagie, Franklin E.
 302 Second Nat. Bk. Bldg.
 Harmon, C. J. 407 Med. Arts Bldg.
 Harmon, G. H. 407 Med. Arts Bldg.
 Hays, George R.
 401 Second Nat. Bk. Bldg.
 Hill, H. D. 412 Med. Arts Bldg.
 Hoffman, Curtis R.
 405 First Nat. Bk. Bldg.
 Holland, Emory E. 1907 E. Main
 Hufnagel, Chas. A.
 516 First Nat. Bk. Bldg.
 Hunt, G. J. 130 Med. Arts Bldg.
 Johnson, P. S. 215 Med. Arts Bldg.
 Kime, Charles E. 51 S. Eighth
 Krueger, Fredk. W. 45 S. Seventh
 Laird, Leslie A. Rich. State Hosp.
 Lee, G. W. 139 Medical Arts Bldg.
 Logan, James Z.
 203 Second Nat. Bank Bldg.
 Mader, John H. 808 South A
 Malcolm, R. 127 Medical Arts Bldg.
 Meredith, Elwood J.
 203 Medical Arts Bldg.

Miller, I. M. Richmond State Hosp.
 Pentecost, Paul S. 98 W. Main
 Ross, Harry P.
 410 Second Nat. Bank Bldg.
 Ross, James S. 302 Colonial Bldg.
 Ross, Louis F.
 308 Second Nat. Bank Bldg.
 Runge, Paul W. 1426 East Main
 Sage, Charles V. 48 S. Eleventh
 Shields, Tom S. 47 S. Eleventh
 Smith, John R. 510 South "A"
 Snyder, M. C. 130 Med. Arts Bldg.
 Stamper, L. A. 402 Med. Arts Bldg.
 Stepleton, J. D. Reid Mem. Hosp.
 Sweet, H. E. 20 S. Twenty-second
 Taylor, W. R. 308 Med. Arts Bldg.
 Vance, W. C. 136 Med. Arts Bldg.
 Wanninger, Horace
 408 2nd Nat. Bank Bldg.
 Warrick, Francis B. 1426 E. Main
 Weinstein, E. B. 204 Colonial Bldg.
 Wertenberger, Morris D.
 Reid Memorial Hosp.
 Whallon, Arthur J. 29 S. Tenth
 Wisener, G. H. 213 Med. Arts Bldg.
 Yencer, Martin W. (H)
 22 N. Fourteenth
 Shepard, Fred F. 202 W. Liberty
 College Corner, Ohio
 Hiatt, Russell, 1825 H St., N. W.,
 Washington, D. C.
 Faucett, Ralph E. 2363 Crescent
 San Diego, Calif.
 Poston, Clement L. 4024 Kingsbury
 Rd., Memphis, Tenn.

WELLS COUNTY

Bluffton

Annis, Homer B. 303 S. Main
 Aucreman, Charles S. 303 S. Main
 Brickley, Harry D. 227 S. Main
 Buckner, Joy F. Bluffton
 Carter, Fred S. 303 S. Main
 Caylor, Harold D. 303 S. Main
 Caylor, T. E. 303 S. Main
 Collett, Hugh S. 303 S. Main

Cook, Robert G. 303 S. Main
 Dorrance, Thos. O. 303 S. Main
 Eisaman, Jack L. 303 S. Main
 Gitlin, Max M. 121½ E. Market
 Gitlin, William A. 121 E. Market
 Hamilton, O. G. 227 S. Main
 Holtzman, Paul W. 303 S. Main
 Johnston, Robert L. 303 S. Main
 Mead, Clarence H. 227 S. Main
 Nickel, Allen 303 S. Main
 Sherman, Robert M. 303 S. Main
 Tirman, Wallace S. 303 S. Main
 Yoder, Richard P. 303 S. Main
 Gingerick, C. M. Liberty Center
 Davidoff, Manuel A. Ossian
 Hardin, Wayne E. Ossian
 Jackson, John F. Ossian

WHITE COUNTY

Galbreth, Jesse P. Burnettsville
 Derhammer, George L. Brookston
 Mather, Robert Brookston
 Netherton, Clyde R. Chalmers
 Houser, Wayne W. Monon
 McClure, Stanley E. Monon
 Carney, John C. Monticello
 Gable, Homer B. Monticello
 Greist, H. W. (H) Monticello
 Hibner, Nolan Monticello
 Morris, Warren V. Monticello
 Mayfield, Clifford H. Reynolds
 Forbes, Violet M. Crabbe. Wolcott

WHITLEY COUNTY

Briggs, Jesse H. Churubusco
 Haller, Robert L. Churubusco
 Hershey, Ernest A. Churubusco
 Heritier, Claude J. Columbia City
 Hull, James E. Columbia City
 Langohr, John Columbia City
 Lehmberg, Otto F. Columbia City
 Nolt, Ernest V. Columbia City
 Pence, Benjamin F. Columbia City
 Thompson, Frank Columbia City
 Garber, Paul A. South Whitley
 Huffman, Verlin P. South Whitley



MEMBERS OF WOMAN'S AUXILIARY

BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. Norman E.
365 N. Harrison
Habegger, Mrs. M. L. 505 Clark
Reusser, Mrs. Amos 256 Sprunger

Decatur

Burk, Mrs. James 221 S. Third
Carroll, Mrs. John C. R. R. 1
Duke, Mrs. Ben E. 145½ S. Second
Girod, Mrs. A. H. 1004 W. Monroe
Kohne, Mrs. G. J. 304 W. Adams
Rayl, Mrs. C. C. 334 S. First
Reppert, Mrs. Roland L. Road 224
Terveer, Mrs. John B.

415 W. Madison

Zwick, Mrs. H. F. 401 E. Rugg

Geneva

Schetgen, Mrs. Charlotte Geneva
Lehman, Mrs. H. B. R. R. 1

ALLEN COUNTY

Fort Wayne

Adams, Mrs. J. R. 621 W. Berry
Aiken, Mrs. N. E. 1923 E. State
Aldrich, Mrs. Harry
2710 Broadway
Bailey, Mrs. P. B. 1215 Crescent
Baltes, Mrs. J. H. 4816 Beaver
Bash, Mrs. W. E. 4626 Stratford
Beams, Mrs. Ralph

3206 S. Anthony

Beierlein, Mrs. Karl M. Butler Rd.
Benninghoff, Mrs. Daniel R.

2725 West Dr.

Berghoff, Mrs. Raymond J.

2009 Forest Park

Blosser, Mrs. H. V. 1122 W. Wash.
Bolman, Mrs. R. M. 4401 Indiana
Bolman, Mrs. Morton 1038 Maxine
Bowers, Mrs. G. T. 2609 East
Bowers, Mrs. J. W. 817 E. Wash.
Brosius, Mrs. Robt. 1530 Lake
Bruggeman, Mrs. H. O.

1202 W. Wash.

Buckner, Mrs. Doster Bass Rd.
Bulson, Mrs. Eugene L.

4301 Pembroke Lane

Calvin, Dr. Jessie C. 312 W. Wayne
Cameron, Mrs. D. F.

2724 N. Clinton

Carlo, Mrs. E. R. 4633 Crestwood
Cartwright, Mrs. Emor L.

529 Packard

Catlett, Mrs. M. B. 1143 W. Rudisill
Clark, Mrs. Wm. R. 4515 Beaver
Cooney, Mrs. C. J. 4401 Indiana
Cowan, Mrs. J. C. Lincoln Hwy. E.
Craig, Mrs. Richard

449 E. Wildwood

Culp, Mrs. Jno. E. 1216 Illsley Dr.
Dancer, Mrs. C. R. 905 Columbia
Dunstone, Mrs. H. C. 4134 Indiana
Eberly, Mrs. K. C. 1240 W. Rudisill
Elston, Mrs. L. W. Stelhorn Pk.
English, Mrs. C. H. 2509 Webster
Estlick, Mrs. R. E. 4223 Beaver
Ferguson, Mrs. A. N.

3432 N. Wash.

Fichman, Mrs. A. M. 323 W. Berry
Foy, Mrs. H. W. 1816 Forest Pk.
Garton, Mrs. Harry W.

R. R. 6, Hamilton Rd.

Gerding, Mrs. Wm. 2943 Central
Gessler, Mrs. Wm. F.

3927 S. Harrison

Glock, Mrs. Maurice E.

1913 Forest Pk.

Glock, Mrs. Wayne R.

921 Lexington Ct.

Graham, Mrs. G. M. 3813 Hiawatha
Haffner, Mrs. Herman C.

3606 Mulberry Rd.

Hamilton, Mrs. Emory

2405 Florida Dr.

Harshman, Mrs. L. Potter

2704 N. Clinton

Harvey, Mrs. H. C. 2228 Crescent

Hasewinkle, Mrs. A. M.

1807 E. Rudisill

Hattendorf, Mrs. A. P.

4041 Old Mill Rd.

Havens, Mrs. Russell

1102 Pemberton Dr.

Hoffman, Mrs. Arthur

2205 S. Calhoun

Hoffmann, Mrs. Sterling P.

234 E. Maple Grove

Hoetzer, Mrs. E. M. 1720 Florida

Holsinger, Mrs. R. E. 3502 Bowser

Horton, Mrs. G. R. 3329 Hoagland

Jurgenson, Mrs. Walter

454 Arcadia Ct.

Kidder, Mrs. O. T.

Irene Byron San.

Kruse, Mrs. E. H. 2805 Fairfield

Ladig, Mrs. D. S. 1014 Rivermet

Lehner, Mrs. Jno. 1119 Maxine

Lenk, Mrs. Geo. 1520 Kensington

Lloyd, Mrs. Robt. 3609 S. Anthony

Lohman, Mrs. Robt. 2138 Owaissa

Lohman, Mrs. M. R. 2138 Owaissa

Loudermilk, Mrs. J. L.

1723 Pemberton

McArdle, Mrs. E. G. 1133 Rudisill

McBride, Mrs. W. O.

610 Beechwood Circle

McCoy, Mrs. R. R. 3701 S. Harrison

McDowell, Mrs. G. A.

2322 Forest Pk. Blvd.

McEachern, Mrs. Cecil G.

3914 Wasonaissa

McKeeman, Mrs. Donald H.

1615 Ardmore

McNairy, Mrs. D. J. 4522 Beaver

Mendenhall, Mrs. E. N.

232 S. Cornell Circle

Mercer, Mrs. S. R. 3235 N. Wash.

Meyer, Mrs. T. O. 4438 Wilmerre

Michaelis, Mrs. S. C.

4311 Marquette

Miller, Mrs. C. G. 457 W. Oakdale

Miller, Mrs. P. H. 417 W. Pontiac

Miller, Mrs. M. F. 1115 Illsley

Miller, Mrs. O. J. 1102 Kensington

Miller, Mrs. R. H. 1322 W. Foster

Moats, Mrs. Geo. E.

2107 Kensington

Moravec, Mrs. A. E. 4711 Old Mill

Mortenson, Mrs. Leland J.

1310 W. Foster

Mueller, Mrs. L. W. 3423 S. Wash.

Murdock, Mrs. Harvey L.

1212 Kensington

Nahrwold, Mrs. E. W.

3314 Irvington

Nil, Mrs. Jno. H. 1116 Charlotte

O'Rourke, Mrs. Carroll

604 W. Berry

Oyer, Mrs. J. H. 2206 Wawonaissa

Parker, Mrs. C. B. 4520 Beaver

Perrin, Mrs. K. F. Maysville Rd.

Perry, Mrs. Fredk. 709 Kinnaird

Popp, Mrs. M. F. 3148 Parnell

Prentiss, Mrs. N. H. 919 Parkview

Ranke, Mrs. Henry 3112 Beaver

Ray, Mrs. H. A. 325 E. Creighton

Rhamy, Mrs. B. W. 3452 Portage

Rice, Mrs. B. W. 1023 Kinnaird

Rissing, Mrs. Walter

3200 Irvington

Rockey, Mrs. Noah A. 2411 Florida

Rodriquez, Mrs. Juan

4720 Crestwood

Roser, Mrs. A. J. Leesburg Rd.

Rossiter, Mrs. D. L. 724 W. Oakdale

Rothberg, Mrs. Maurice

4801 Tacoma

Rothchild, Mrs. Charles J.

3015 N. Anthony

Salon, Mrs. Harry W. 2423 Fairfield

Salon, Mrs. N. L. 1024 Kinnaird

Savage, Mrs. A. R. 102 Fairhill

Schafer, Mrs. Donald W., Jr.

227 W. Sherwood

Schlegel, Mrs. Edward W.

2219 N. Anthony

Schmoll, Mrs. R. J. 2129 Owaissa

Scoins, Mrs. W. H.

R. R. 8, Taylor Rd.

Scott, Mrs. H. Vaughn

5224 Fairfield

Shinabery, Mrs. Lawrence

1850 Broadway

Singer, Mrs. E. C. 825 Oakdale

Smith, Mrs. G. A. Lincoln Hwy. E.

Somers, Mrs. G. H. 227 W. Fleming

Stauffer, Mrs. Richard

2116 Wawonaissa

Stellner, Mrs. Howard A.

4314 S. Calhoun

Stier, Mrs. Paul 3807 Fairfield

Tennant, Mrs. David

4533 Lafayette Esplanade

Terrill, Mrs. R. W. 4727 Old Mill

Thornton, Mrs. W. E. 601 Oakdale

VanBuskirk, Mrs. E. M.

920 Maxine Dr.

Wallace, Mrs. J. Clifford

4003 S. Harrison

Warfield, Mrs. C. H.

1809 Kensington

Welty, Mrs. S. G. 509 Oakdale

Wilkins, Mrs. R. W. 4839 Old Mill

Williams, Dr. Berneice

3526 N. Wash.

Wilson, Mrs. Leslie 2810 S. Wayne

Wright, Mrs. W. C. 1834 Pemberton

Wyatt, Mrs. James L., Jr.

2120 Kensington

Zehr, Mrs. Noah 301 W. Creighton

Zweig, Mrs. Elmer 3365 Garland

ALLEN COUNTY

(Fort Wayne—Continued)

Indianapolis

Johnston, Mrs. D. D.
2444 N. Meridian

New Haven

Dahling, Mrs. C. W. 1206 Powers
Emenhiser, Mrs. D. C.
Emenhiser, Mrs. J. L.
Morris, Mrs. E. E. 1015 Bell

AFFILIATE MEMBERS

Bluffton

Brickley, Mrs. H. D. 227 S. Main
Buckner, Mrs. J.
Hamilton, Mrs. O. G.203 E. Central
Mead, Mrs. C. H. 211 W. Wash.
Morris, Mrs. G. B. 116 W. Market

BARTHOLOMEW COUNTY

Columbus

Adler, Mrs. D. L. Mead Village
Beggs, Mrs. L. F. 1641 Franklin
Carpenter, Mrs. T. D. 2328 Gilmore
Dagley, Mrs. Hubert

1103 California

Davis, Mrs. Marvin 2228 Lafayette
Fisher, Mrs. W. S. 906 Franklin
Hart, Mrs. Robt. B. 1203 16th
Kamman, Mrs. H. H. 821 Fifth
Kincaid, Mrs. J. C. 4 Mi. House Rd.
Marr, Mrs. Griffith 1513 17th
Norton, Mrs. H. J. 909 Pearl
Overshiner, Mrs. Lyman

1715 Franklin

Ryan, Mrs. Wm. J. 2244 Pearl
Schmitt, Mrs. R. K. 2639 Riverside
Williams, Mrs. E. W. 1902 Franklin
Wissman, Mrs. W. 1930 Lafayette
Yoder, Mrs. D. D. 713 Lafayette
Zaring, Mrs. Byron 2419 Riverside

Hope

Dudding, Mrs. J. E. 26 S. Main
Hoover, Mrs. Josephine N. Main

BENTON COUNTY

Taylor, Mrs. W. H. Ambia
Atkinson, Mrs. C. W. Boswell
Flack, Mrs. Minnie Boswell
Muller, Mrs. L. P. Boswell
Carnes, Mrs. Wm. Earl Park
Altier, Mrs. Wm. Fowler
Turley, Mrs. Verne L. Fowler
Smith, Mrs. Chas. G. Otterbein
Parker, Mrs. E. E. Oxford
Scheurich, Mrs. Virgil Oxford
Hubbard, Mrs. Eva3026 Wisconsin Ave., NW,
Apt. 25, Washington, D. C.

CARROLL COUNTY

Van Kirk, Mrs. John Burlington
Brown, Mrs. Tom Delphi
Crampton, Mrs. Charles Delphi
Gros, Mrs. Hubert Delphi
Wagoner, Mrs. George Delphi
Adams, Mrs. Max R. Flora
McLaughlin, Mrs. James R. Flora
Mullin, Mrs. H. Y. Rockfield

CASS COUNTY

Dutchess, Mrs. C. E. Galveston

Logansport

Adamski, Mrs. Michael 614 17th
Bailey, Mrs. E. W. 2522 North St.
Ballard, Mrs. Chas. A. R. R. 4
Bradfield, Mrs. John C. R. R. 4
Cooper, Mrs. Thos. L. 2104 North
Davis, Mrs. John C. 2119 North
Fitzgerald, Mrs. B. E. 1930 High
Hall, Mrs. Bernard 1907 Broadway
Hedde, Mrs. E. L. 309 Seventh
Hickman, Mrs. W. R. 924 High
Hillis, Mrs. Lowell2508 E. Broadway
Holloway, Mrs. W. A.200 Eel River
Holmes, Mrs. W. W. R. R. 4
Jewell, Mrs. E. B. 2019 High
Jones, Mrs. J. Carl Michigan Ave.
Keefe, Mrs. T. L. 900 E. Broadway
Morrical, Mrs. Russell1016 Michigan
Schultz, Mrs. H. M. 412½ Fourth
Stewart, Mrs. M. B. 1308 High
Terflinger, Mrs. Fred W.2607 Broadway
Viney, Mrs. Charles L. R. R. 4
Wilson, Mrs. Paul H. 207 18th
Winter, Mrs. Donald K. 89 Ninth
Newcomb, Mrs. W. K. Royal Center
Rollins, Mrs. Russell Royal Center
Lybrook, Mrs. Thomas D. E.

Young America

CLARK COUNTY

Charlestown

Goodman, Mrs. Eli 221 Clark

Jeffersonville

Adair, Mrs. S. L. Utica Pike
Bizer, Mrs. Mier 218 Kewanna
Bruner, Mrs. R. W. 804 E. Court
Buckley, Mrs. Ernest P.Arctic Springs Camp
Burman, Mrs. R. G. Utica Pike
Carlberg, Mrs. D. L. 514 Graham
Carney, Mrs. J. L. 203 Sparks
Dare, Mrs. Lee A. 215 Sparks
Forsee, Mrs. Norman E.17 Spring Hill Apt.
Huoni, Mrs. J. S. 6 Blanchel Ter.
Isler, Mrs. Nathaniel901 Morningside Dr.
Weems, Mrs. Mallory P.Rte. 1, Hopkins Lane
Regan, Mrs. George Sellersburg
Sturgis, Mrs. Don Sellersburg
Vandervert, Mrs. Arthur

Sellersburg

DELAWARE-BLACKFORD
COUNTYBrown, Mrs. Stewart Albany
Hurley, Mrs. John Daleville
Rutledge, Mrs. Jeanne Daleville
Tucker, Mrs. Oral A. Daleville
Lingeman, Mrs. Roger E. Eaton
Downward, Mrs. Leland Gaston
Montgomery, Mrs. Lall J. Gaston

Muncie

Adams, Mrs. W. B. W. Jackson Pk.
Alvey, Mrs. Chas. Torquay Rd.

Anthony, Mrs. Harvey

822 W. Charles

Aucerman, Mrs. Chas. Torquay Rd.
Ball, Mrs. Clay A. 1015 Linden
Bibler, Mrs. Henry 311 W. Adams
Botkin, Mrs. C. G. 2904 Riverside
Botkin, Mrs. Tom 624 N. Elm
Bowles, Mrs. John 406 Wayne
Brown, Mrs. K. T. 905 E. Adams
Butterfield, Mrs. R. 1002 W. Gilbert
Clauser, Mrs. Eldo 1 Briar Rd.
Clevenger, Mrs. Jos.3124 University
Cline, Mrs. Geo. 315½ W. Jackson
Cole, Mrs. R. E. 431 W. Howard
Covalt, Mrs. Wendell E. R. R. 7
Cure, Mrs. E. T. 913 University
Deutsch, Mrs. Wm. 2100 Petty Rd.
Downing, Mrs. Frank220 W. Jackson
Dunn, Mrs. Ferrell 1417 Wheeling
Eissman, Mrs. Eugene2724 W. Gilbert
Funk, Mrs. Jno. W. W. Riverside
Garling, Mrs. L. C. 37 Briar Rd.
Greiber, Mrs. M. F. 3001 Devon Rd.
Hall, Mrs. O. A. 3121 Gilbert
Hayes, Mrs. Theodore920 W. North
Henderson, Mrs. R. A.300 Shady Lane
High, Mrs. Ralph 911 E. Jackson
Hill, Mrs. Frank 321 W. Calvert
Hill, Mrs. Howard 402 W. Jackson
Hill, Mrs. Robt. 216 W. Jackson
Hostetter, Mrs. I. S. 3010 Riverside
Imhof, Mrs. J. D. Graystone Apts.
Kammer, Mrs. W. F. 919 W. Main
Kemper, Mrs. Arthur 600 E. Wash.
Kirshman, Mrs. F. E. 41 Briar Rd.
McMichael, Mrs. Robert316 W. Adams
Miller, Mrs. Chas. 917 E. Main
Molloy, Mrs. Wm. 619 E. Charles
Moss, Mrs. M. J. 2526 W. Main
Owens, Mrs. Rich. R. 2613 Godman
Owens, Mrs. Thos. 606 E. Charles
Owens, Mrs. W. O. 2600 Godman
Poland, Mrs. U. G. 303 E. Wash.
Quick, Mrs. Wm. 2009 University
Rea, Mrs. C. G. 412 University
Rettig, Mrs. Arthur611 W. Howard
Rivers, Mrs. Glynn 1333 N. Walnut
Rush, Mrs. Clyde E. 100 N. Cherry
Schulhof, Mrs. M. G. 1406 Wheeling
Silvers, Mrs. J. M. 220 W. Adams
Stocking, Mrs. B. W.1711 Riverside
Tindal, Mrs. Edw. 423 W. Jackson
Tomlin, Mrs. Hugh 921 W. Main
Trent, Mrs. I. N. 415 E. Adams
Venis, Mrs. Kemper 502 Wade
Wasley, Mrs. Malcolm 2010 S. Vine
Williams, Mrs. J. H. 905 W. North
Young, Mrs. G. S. 114 Berwyn Rd.
Hinchman, Mrs. Jean Parker
Moore, Mrs. Wm. C. Yorktown

DUBOIS COUNTY

Ferdinand

Backer, Mrs. H. G. Ferdinand

Holland

Williams, Mrs. Chas. Holland

DUBOIS COUNTY

Huntingburg

Blessinger, Mrs. Louis H.
 Bretz, Mrs. John...222 Van Buren
 Bretz, Mrs. W. D....214 Fourth
 Lukemeyer, Mrs. L. C....216 Main
 McKinney, Mrs. S. L...517 Fourth
 Steinkamp, Mrs. E. F. 302 Walnut
 Stork, Mrs. H. K.
 Wagoner, Mrs. James M.
 Williams, Mrs. F. P....511 Geiger

Jasper

Casper, Mrs. John
 Casper, Mrs. Jos....116 E. Seventh
 Heck, Mrs. M. C....512 Newton
 Held, Mrs. G. A....1451 Mill
 Klamer, Mrs. C. H....424 W. Sixth

ELKHART COUNTY

Elkhart

Bender, Mrs. R. L...309 East Blvd.
 Bloom, Mrs. G. R....130 Glendale
 Bolin, Mrs. R. S. 1853 E. Beardsley
 Bowdoin, Mrs. George E.
 1029 W. Lexington
 Compton, Mrs. Walter
 225 Greenleaf
 Cormican, Mrs. Herbert
 1621 E. Jackson
 Crandall, Mrs. L. A., Jr....Rte. 3
 Elliott, Mrs. L. A....2001 Stevens
 Fleming, Mrs. Claude F.
 229 W. Jackson
 Fleming, Mrs. J. M.
 2220 E. Jackson
 Goodrum, Mrs. W. R.
 416 W. Lexington
 Horswell, Mrs. R. G.
 1629 E. Jackson
 Hull, Mrs. A. W....905 Strong
 Hunn, Mrs. M. F. 202 W. Beardsley
 Kintner, Mrs. B. E....304 Blaine
 Kistner, Mrs. Arthur W.
 102 W. Beardsley
 Koehler, Mrs. Elmer G....R. R. 2
 Lundt, Mrs. M. O....521 S. Second
 Markel, Mrs. I. J. 215 W. Franklin
 Mendez, Mrs. Carlos...325 Superior
 Miller, Mrs. Hugh...315 W. Jackson
 Miller, Mrs. Sam T....1230 Prairie
 Mininger, Mrs. Edward P.
 413 W. Franklin

Mishkin, Mrs. Irving
 217 N. Riverside
 Paff, Mrs. Wm. A....198 Simpson
 Paine, Mrs. Geo. A....419 Modrell
 Patrick, Mrs. G. B....Equity Bldg.
 Sears, Mrs. M. M....W. Indiana
 Spray, Mrs. Page....658 Kilbourn
 Stauffer, Mrs. W. A....701 Strong
 Stout, Mrs. R. B....1501 Greenleaf
 Stubbins, Mrs. Wm....R. R. 1
 Swihart, Mrs. L. F. 2120 Broadmoor
 Todd, Mrs. D. D....2001 E. Jackson
 Wilson, Mrs. O. E....922 Gordon
 Work, Mrs. James A.

No. 4, St. Joseph Manor

GOSHEN

Amstutz, Mrs. H. C....2001 S. Main
 Bender, Mrs. C. K....654 S. 5th
 Freeman, Mrs. C. F. 309 E. Wash.
 Hostettler, Mrs. C. M....1602 S. 8th
 Kelly, Mrs. W. R....310 E. Monroe
 Kinzie, Mrs. D. K. 460 Sunset Blvd.
 Martin, Mrs. Floyd S....R. R. 5

Nelson, Mrs. D. Chester 1210 S. 8th
 Simmons, Mrs. Lloyd H. 6063 S. 3rd
 Vander Bogart, Mrs. H. E.

1411 S. 8th
 Westfall, Mrs. Geo...214 E. Lincoln
 Yoder, Mrs. A. C....816 S. 6th
 Neidballa, Mrs. E. G....Bristol
 Schlosser, Mrs. H. C....Bristol
 Chandler, Mrs. L. H....Millersburg
 Fleetwood, Mrs. R. A....Nappanee
 Kendall, Mrs. F. M....Nappanee
 Price, Mrs. Douglas....Nappanee
 Price, Mrs. M. D....Nappanee
 Slabaugh, Mrs. L. M....Nappanee
 Fosbrink, Mrs. E. L....Syracuse
 Hannah, Mrs. J. W....Wakarusa

FLOYD COUNTY

Engleman, Mrs. H. K. Georgetown

NEW ALBANY

Baker, Mrs. A. M.
 2523 Glenwood Ct.
 Baxter, Mrs. James W., Jr.
 426 Woodrow
 Baxter, Mrs. Samuel M....Centralia
 Best, Mrs. M. M., Jr.
 R. R. 21, Lilly Lane
 Bird, Mrs. J. E....1308 E. Spring
 Briscoe, Mrs. C. E. 1413 E. Spring
 Brown, Mrs. Kenneth H.
 1654 Hedden Park
 Byrn, Mrs. H. W....330 Beharrell
 Cannon, Mrs. Daniel H.
 Box 161, Crestview
 Cohn, Mrs. Phillip Silvercrest San.
 Davis, Mrs. Parvin M....Paoli Pike
 Day, Mrs. Geo. H....Hausfeldt Lane
 Edwards, Mrs. William F.
 615 Beharrell
 Garner, Mrs. W. H....922 E. Spring
 Gentile, Mrs. John P. Floyds Knobs
 Hall, Mrs. W. A. 1509 Shelby Place
 Hauss, Mrs. A. P....Silver Hills
 LaFollette, Mrs. Robert E.
 2510 Glenwood Park
 Leuthart, Mrs. C. P. 1410 E. Spring
 McCullough, Mrs. J. Y....Centralia
 Pace, Mrs. Jerome....Silvercrest
 Paris, Mrs. John M.
 2003 Lindberg Ct.
 Pierson, Mrs. Percy R....1430 Silver
 Robertson, Mrs. A. N....323 E. 9th
 Rogers, Mrs. S. T....1017 E. Spring
 Sloan, Mrs. H. P....1207 E. Spring
 Strange, Mrs. M. B....10 Bond Rd.
 Streepey, Mrs. J. I. 1102 E. Spring
 Tyler, Mrs. F. T....Daisy Lane
 Voyles, Mrs. H. E....425 Beharrell
 Weaver, Mrs. W. W. 1104 E. Spring
 Winstandley, Mrs. William C.
 815 Vincennes
 Wolfe, Mrs. M. F....2303 E. Spring
 Wolfe, Mrs. Nelson A....1615 Ind.

FULTON COUNTY

Miller, Mrs. Virgil....Akron
 Stinson, Mrs. A. E....Athens
 Kelsey, Mrs. Lawrence....Kewanna
 Kraning, Mrs. K. K....Kewanna
 Herendeen, Mrs. E. V....Rochester
 King, Mrs. Milo O....Rochester
 Musselman, Mrs. Glen....Rochester
 Rowe, Mrs. Howard....Rochester
 Richardson, Mrs. C. L....Rochester
 Shafer, Mrs. H. O....Rochester
 Stinson, Mrs. Dean K....Rochester

GRANT COUNTY

Malott, Mrs. FredConverse
 Koontz, Mrs. Wm.....Gas City

MARION

Ayers, Mrs. W. W....915 W. 6th
 Bloom, Mrs. Ward A....Quarry Rd.
 Brown, Mrs. R. M....825 Euclid
 Daniels, Mrs. G. R....822 W. 4th
 Davis, Mrs. M. S....723 Euclid
 Diamond, Mrs. L. L....617 Spencer
 Eshleman, Mrs. L. H.
 2927 S. Washington
 Fisher, Mrs. Henry
 1502 S. Washington
 Fisher, Mrs. Pierre...1714 E. 34th
 Ganz, Mrs. Max....804 W. 3rd
 Hummel, Mrs. R. M.
 3751 S. Nebraska

McIlwain, Mrs. Robt. 2107 S. Boots
 Miller, Mrs. H. A....1010 W. 4th
 Powell, Mrs. J. P....1416 S. Adams
 Renbarger, Mrs. Lester L.

Wabash Park
 Rhorer, Mrs. J. G....Wabash Park
 Rifner, Mrs. E. S....VanBuren
 Simmons, Mrs. Fred'k...520 Whites
 Sullenger, Mrs. A. A.
 2821 S. Nebraska

Warren, Mrs. C. B....803 W. 6th
 Young, Mrs. R. G....112 E. 14th

GIBSON COUNTY

Geick, Mrs. R. G....Ft. Branch
 Klein, Mrs. H. P....Ft. Branch
 Arthur, Mrs. H. H....Hazelton

OAKLAND CITY

Clark, Mrs. C. M. 511 W. Columbia
 Turner, Mrs. M. S.....
 Wood, Mrs. R. W....628 Oak

OWENSVILLE

Fisher, Mrs. G. E.
 Montgomery, Mrs. J. R.
 Strickland, Mrs. K. S.

PRINCETON

Alexander, Mrs. H. H....427 State
 Carpentier, Mrs. H. F. 319 E. State
 Folck, Mrs. J. K....530 N. Hart
 Graves, Mrs. O. M....116 E. Spruce
 McCarty, Mrs. V....403 W. Spruce
 McElroy, Mrs. R. S....704 W. State
 Peck, Mrs. J. F....218 W. Broadway
 Weitzel, Mrs. R. E. 303 W. Walnut

HANCOCK COUNTY

Johnston, Mrs. Wm. R.
 Charlottesville
 Scott, Mrs. Robert..Charlottesville

FORTVILLE

Ferrell, Mrs. J. E....N. Merrell
 Ferrell, Mrs. M. B....2nd St. S.
 Navin, Mrs. H. K....N. Merrell

Greenfield

Allen, Mrs. Joseph....17 E. South
 Endicott, Mrs. Wayne
 Gibbs, Mrs. Chas....203 E. North
 Gill, Mrs. D. D....328 Park
 Woods, Mrs. James
 Larrabee, Mrs. W. H.
 New Palestine
 Kuhn, Mrs. Robert....Wilkinson

HOWARD COUNTY

Denton, Mrs. Larkin....Greentown
Shoup, Mrs. H. B.....Greentown

Kokomo

Adams, Mrs. C. J.
1216 W. Superior
Boughman, Mrs. J. D.
1515 W. Jefferson
Bowers, Mrs. Copeland
1530 W. Taylor
Bowers, Mrs. G. B.
421 Morningside Dr.
Bowers, Mrs. John
1535 W. Jefferson
Bruegge, Mrs. T. J.
1414 Kingston Rd.
Clarke, Mrs. E. R.
1400 W. Sycamore
Conley, Mrs. T. M.
1016 W. Superior
Craig, Mrs. R. A....113 Leafy Lane
Cuthbert, Mrs. F. S.
1027 W. Walnut
Druley, Mrs. G. N....402 Ruddell Dr.
Ferry, Mrs. P. W.
1207 W. Sycamore
Good, Mrs. R. P.....417 Conradt
Hutto, Alma1012 W. Walnut
Hutto, Miss Arvilla
1012 W. Walnut
Hutto, Mrs. W. H.....211 Conradt
Jewell, Mrs. G. M....1525 W. Walnut
Kratzer, Mrs. E. F....320 E. Walnut
Lung, Mrs. B. D.....115 Conradt
Martin, Mrs. W. J.
409 W. Sycamore
Meiner, Mrs. J. A....924 S. Wash.
McIndoo, Mrs. R. E....820 W. Taylor
Morrison, Mrs. D. A.
1719 W. Taylor
Morrison, Mrs. W. R.
413 Conradt Ave.
Murray, Mrs. F. C.
1329 W. Jefferson
Paris, Mrs. D. W....South Lafontain
Phares, Mrs. R. W.
905 W. Mulberry
Rhorer, Mrs. H. M....511 Sycamore
Schuler, Mrs. R. P....502 N. Main
Schuler, Miss Lucy....502 N. Main
Schwartz, Mrs. F. C.
1503 Kingston Road
Scott, Mrs. R. F....1201 W. Maple
Shenk, Mrs. E. M....306 N. Webster
Sorenson, Mrs. Raymond
1526 W. Sycamore
Spangler, Mrs. Jesse
214 E. Mulberry
Evans, Mrs. Robert....Russiaville
Tranter, Mrs. W. F....Sharpsville

HUNTINGTON COUNTY

Omstead, Mrs. L. W.....Andrews
Huntington
Brubaker, Mrs. H. S....919 Poplar
Casey, Mrs. S. M....408 E. Market
Erehart, Mrs. M. G. Maple Gr. Rd.
Everett, Mrs. Cecil....1523 Poplar
Eviston, Mrs. J. B....1392 Poplar
Galbreath, Mrs. R. S....16 W. Wash.
Gray, Mrs. Paul M....340 E. Market
Grayston, Mrs. F. W....708 N. Jeff.
Grayston, Mrs. W. S....303 E. Mkt.
Johnston, Mrs. R. G....339 E. Market
Marks, Mrs. H. H....1433 Cherry
Meiser, Mrs. R. D....1738 Cherry

Mitman, Mrs. F. B....1470 Poplar
Nie, Mrs. G. M.....1518 Cherry
Ware, Mrs. J. R.....622 Henry
Woods, Mrs. H. C.....Markle
Bennett, Mrs. J. B.....Warren
Black, Mrs. Claude S.....Warren
Bonifield, Mrs. H. F.....Warren
Smith, Mrs. L. W.....Warren

JOHNSON COUNTY

Edinburg

Baker, Mrs. J. V.
215 W. Main Cross
Deppe, Mrs. C. F. 710 E. Thompson
Michaels, Mrs. J. F.
207 E. Main Cross

Franklin

Eaton, Mrs. L. D. 651 W. Jefferson
Jones, Mrs. C. A....589 N. Graham
Murphy, Mrs. H. E....150 N. Main
Payne, Mrs. C. F....147 N. Main
Portteus, Mrs. W. L....1000 E. King
Province, Mrs. O. A....99 W. Water
Province, Mrs. W. D. 186 Maple La.
Records, Mrs. A. W....216 E. Jeff.
Wilson, Mrs. R. C.....351 E. King

Greenwood

Brown, Mrs. G. E....52 S. Madison
Cox, Mrs. Edith....375 W. Wiley
Craig, Mrs. J. A.....E. Pearl
Machledt, Mrs. John H.
243 S. Madison Ave.
Sheek, Mrs. K. L....165 N. Brewer
Tiley, Mrs. G. A....41 N. Madison
Woodcock, Mrs. C. E.
240 S. Madison Ave.

LAKE COUNTY

East Chicago

Arnold, Mrs. M.....4026 Euclid
Bonaventura, Mrs. A. P.
1604 E. 142nd
Boys, Mrs. F. F....4143 Northcote
Brauer, Mrs. A.....4129 Ivy
Cotter, Mrs. Ed....4220 Homerlee
Cotter, Mrs. Thos. F....4221 Ivy
Ernst, Mrs. H. C....4219 Baring
Fleischer, Mrs. J. C....4135 Ivy
Grosso, Mrs. W. 3502 Grand Blvd.
Gustaitis, Mrs. J. W....3510 Ivy
Johns, Mrs. D. R....1211 Beacon
McGuire, Mrs. D. F....1910 142nd
Niblack, Mrs. J. S....4122 Parrish
O'Connor, Mrs. J. J....3717 Ivy
Petronella, Mrs. S. J. 4308 Baring

Gary

Almquist, Mrs. C. O....550 Lincoln
Bendler, Mrs. C. 225 Morningside
Bills, Mrs. R. N.....534 Lincoln
Brady, Mrs. Sam....3619 VanBuren
Carbone, Mrs. Jos....526 Johnson
Danieleski, Mrs. L. S. 3569 Madison
Goldstone, Mrs. A....1430 W. 7th
Goldstone, Mrs. J....600 Cleveland
Goldstone, Mrs. S. R....566 Taft
Harris, Mrs. B. W....1020 W. 5th
Kahan, Mrs. Harry....403 Johnson
Kobrin, Mrs. Meyer....380 McKinley
Kopcha, Mrs. J. E....715 Hayes
Lebioda, Mrs. H. S....3739 Adams
Lorenty, Mrs. T. B....3565 Madison
Mather, Mrs. J. W....East Gary

May, Mrs. R. M....667 VanBuren
Minczewski, Mrs. R. C. 361 Chase
Molengraft, Mrs. C. J. 544 Monroe
Nelson, Mrs. W. A....1002 Warren
Ornelas, Mrs. J. P....4324 Monroe
Palmer, Mrs. R....2006 W. 4th Pl.
Parker, Mrs. H. C....530 Fillmore
Parker, Mrs. John....8540 Pine
Parratt, Mrs. W....3526 Madison
Sala, Mrs. J. J.....537 Taft Pl.
Sala, Mrs. Walter....2035 W. 8th
Senese, Mrs. T. J....581 Johnson
Shellhouse, Mrs. M....3671 Adams
Skeen, Mrs. E. D....650 VanBuren
Stimson, Mrs. H. R....4300 Madison
Trinosky, Mrs. Don....1720 W. 5th
Vye, Mrs. J. P.....3620 Madison
Watts, Mrs. A. A....620 Lincoln
Weiskopf, Mrs. H. S....1720 W. 5th
Wicks, Mrs. C. O....560 VanBuren
Wharton, Mrs. R. O....703 Johnson
Yarrington, Mrs. C. W. 741 Polks
Young, Mrs. G. W....3672 Monroe
Malmstone, Mrs. F. A....Griffith

Hammond

Allegretti, Mrs. H. S....1720 W. 5th
Arrowsmith, Mrs. J. L. 8138 Forest
Beilke, Mrs. C. A.....6806 Huron
Brown, Mrs. S. L....6550 Hohman
Childlaw, Mrs. B. W....29 Wildwood
Cook, Mrs. G. M.....6607 Forest
Eggers, Mrs. H. W....6542 Hohman
Ewing, Mrs. J. K.....55 Kenwood
Elledge, Mrs. Ray....6415 Forest
Gevirtz, Mrs. M. B....6528 Forest
Hack, Mrs. E. C.....7146 Olcott
Handelman, Mrs. E. V....2235 169th
Hopkins, Mrs. J. R....22 Coolidge
Husted, Mrs. Robert 224 Fernwood
Jones, Mrs. E. S.....50 Kenwood
Kenny, Mrs. F. D.....913 175th
King, Mrs. R. W....6422 Moraine
Komoroske, Mrs. J. E. 35 Highland
Koranski, Mrs. D. S. 5231 Hohman
Kretsch, Mrs. R. W. 7214 Hohman
Marks, Mrs. O. L....7111 Olcott
Marks, Mrs. S. P.....539 Cherry
Mathews, Mrs. C. B....6416 Forest
Nakadate, Mrs. K. J. 7335 Calumet
Nelson, Mrs. R. B....6741 Hohman
Nichols, Mrs. W. E....15 Warren
Peck, Mrs. Edw.....411 165th
Ramker, Mrs. D. T....6827 Kennedy
Remich, Mrs. A.....6412 Morane
Rendel Mrs. T. F....7612 Monroe
Rhind, Mrs. A. W....7126 Forest
Row, Mrs. P. Q.....6706 Hohman
Rudolph, Mrs. F. G. 216 Lawndale
Schlesinger, Mrs. J. 7251 Forest
Shanklin, Mrs. E. M....14 Ruth
Stern, Mrs. S. L....1226 Oak Wood
Dupes, Mrs. L. E.....Hobart
Bergen, Mrs. Paul M....Lowell
Combs, Mrs. L. W.....Lowell
Davis, Mrs. Neal.....Lowell
Mirro, Mrs. J. A.....Lowell
Arbeiter, Mrs. Herbert I.
229 Beldon, Munster

Rosevear, Mrs. Henry
230 Beldon, Munster
Jones, Mrs. C. M.
1925 Westpark, Whiting
Thegze, Mrs. G., 123 W. Detroit,
Calumet City, Ill.
Potts, Mrs. Wm., 3543 Ridge Rd.,
East, Lansing, Ill.

LaPORTE COUNTY

LaPorte

Cartwright, Mrs. J. D.
 Elshout, Mrs. Clem. 1303½ Mich.
 Fischer, Mrs. Carl N. 1001 Maple
 Jones, Mrs. J. C. 2102 Michigan
 Jones, Mrs. R. B. 1515 Indiana
 Kelsey, Mrs. R. M. 2107 Monroe
 Kepler, Mrs. R. W. 304 Kingsbury
 Muehleman, Mrs. C. E. 1209 Mich.
 Przednowek, Mrs. A. C. 909 Mad.
 Simon, Mrs. A. R. 1533 Michigan
 Von Asch, Mrs. Geo. 912 Monroe

Michigan City

Armstrong, Mrs. T. D.
 E. Coolspring Ave.
 Baker, Mrs. Warren
 511 E. Coolspring Ave.
 Bankoff, Mrs. M. L. 1412 Wash.
 Bernoske, Mrs. Daniel. 731 Pine
 Donovan, Mrs. Stephen. 702 Pine
 Fargher, Mrs. Francis M.
 Pottawattomie Park
 Feerer, Mrs. Donald. 117 W. 7th
 Flaherty, Mrs. W. T. Long Beach
 Gardner, Mrs. M. D. 2512 Oak
 Gardner, Mrs. R. A. Long Beach
 Gilmore, Mrs. R. A. 803 Wash.
 Grissom, Mrs. R. L. 506 Vail
 Kerrigan, Mrs. J. V.

E. Coolspring Ave.
 Kling, Mrs. V. F. Long Beach
 Kreiger, Mrs. Geo. M. 701 Wash.
 Kubik, Mrs. F. J. 613 Gardena
 Lava, Mrs. I. M.
 509 Lake Shore Drive
 Meyer, Mrs. Mila G. Long Beach
 Piazza, Mrs. L. F. Long Beach
 Plank, Mrs. C. R. Long Beach
 Saide, Mrs. R. A. 1501 Wash.
 Strauss, Mrs. David. 125 E. 5th
 Weinstock, Mrs. A. Rolling Prairie
 Moosey, Mrs. Louis. Union Mills
 Benz, Mrs. O. F. Wanatah
 Hetman, Mrs. M. J. Westville

MADISON COUNTY

Anderson

Aageson, Mrs. Walter. Forest Hills
 Armstrong, Mrs. J. C. 206 E. 14th
 Armstrong, Mrs. R. L. Kilbuck Rd.
 Austin, Mrs. M. A. 238 W. 12th
 Ayres, Mrs. K. D. 2210 Meridian
 Baughn, Mrs. W. L. 1635 W. 12th
 Blassaras, Mrs. C. A. 2005 Bdwy.
 Buckles, Mrs. D. L. 233 W. 8th
 Conrad, Mrs. E. M. 2124 Meridian
 Coy, Mrs. Francis M. 1733 W. 11th
 Dixon, Mrs. Rex W. Forest Hills
 Drake, Mrs. J. C. Madison Hgts.
 Ellis, Mrs. Seth. 335 W. 5th
 Erehart, Mrs. A. D. 1221 Irving
 Fischer, Mrs. W. Grandview Ter.
 Gante, Mrs. Henry W. 2005 Nichol
 Guthrie, Mrs. F. C. 2205 Nichol
 Hart, Mrs. W. D. 1026 W. 8th
 Hensler, Mrs. B. M. R. R. 8
 Jarrett, Mrs. P. E. Grandview Ter.
 Jones, Mrs. A. T. Delaware Court
 Kelly, Mrs. Wendell C. R. R. 8
 King, Mrs. B. A. 1217 Victory Ct.
 King, Mrs. Jos. W. 226 W. 13th
 Lamey, Mrs. P. T. 1740 W. 10th
 Larmore, Mrs. J. L. 1812 Nichols

Litzenberger, Mrs. S. W. For. Hills
 Long, Mrs. Paul L. 1916 W. 9th
 McDonald, Mrs. V. G.

Country Club Estates

Metcalf, Mrs. G. B. 830 W. 8th
 Nesbit, Mrs. L. L. 329 W. 12th
 Patterson, Mrs. Wm. K.

Alexandria Pike

Polhemus, Mrs. W. C.

Brown St. Road

Ross, Mrs. Guy. 1209 Delaware
 Rosenbaum, Mrs. L. E. Forest Hills
 Rozelle, Mrs. C. V. Forest Hills
 Sharp, Mrs. W. L.

Country Club Estates

Wilder, Mrs. Gordon B. 338 W. 8th
 Willson, Mrs. C. L. 2003 Meridian
 Zierer, Mrs. R. O. Madison Heights
 Bishop, Mrs. H. A. Frankton
 Elsten, Mrs. A. W. Lapel
 Bridges, Mrs. W. L. Markleville
 Stamper, Mrs. Jos. Middletown
 McLaughlin, Mrs. C. P. Pendleton
 McVaugh, Mrs. C. C. Pendleton
 Williams, Mrs. F. M., Jr. Pendleton
 Wishard, Mrs. F. B. Pendleton

MARION COUNTY

Indianapolis

Adkins, Mrs. Harold C.
 250 W. Hampton Dr.
 Adkins, Mrs. Onan C. 3635 Watson
 Albertson, Mrs. F. P. 43 N. Vine
 Albright, Mrs. V. 525 Powell Pl.
 Aldrich, Mrs. H. D. 3029 Park
 Alvis, Mrs. E. O. R. R. 14, Box 203
 Appel, Mrs. R. H.
 Arbuckle, Mrs. Wm. E.

1759 W. Morris

Arnold, Mrs. M. F. New Palestine
 Asher, Mrs. E. O. New Augusta
 Asher, Mrs. J. W. New Augusta
 Bachman, Mrs. A. S. 3239 Winfield
 Bailey, Mrs. L. S. Zionsville
 Bakemeier, Mrs. O. H.

5535 E. St. Clair

Balch, Mrs. James F. 4444 College
 Ball, Mrs. J. E. 823 N. Lesley
 Bartley, Mrs. Max D. 107 E. 48th
 Batman, Mrs. Gordon W.

6116 N. Delaware

Beasley, Mrs. Thomas S.

112 Berkley Rd.

Beaver, Mrs. H. W. 602 N. Beville
 Bibler, Mrs. L. D. 3821 Guilford
 Billman, Mrs. G. S. R. R. 2
 Bloemker, Mrs. E. F. 935 Cameron
 Bowman, Mrs. G. W. 215 Berkley
 Boyer, Mrs. E. B. 6024 E. 10th
 Brady, Mrs. T. A. 440 Berkley
 Brayton, Mrs. John R.

3128 E. Fall Creek Blvd.
 Brayton, Mrs. Lee. 5540 N. Illinois
 Brodie, Mrs. Donald W.

R. R. 12, Box 212, Oaklandon

Brown, Mrs. D. E. 986 N. Audubon
 Brown, Mrs. D., Jr. W. 86th
 Brown, Mrs. G. W. 5365 Guilford
 Brown, Mrs. E. A. 5420 Central
 Brown, Mrs. H. M. 4535 Marcy La.
 Brown, Mrs. W. E. 3702 N. Grant
 Browning, Mrs. James S.

5880 N. Delaware

Browning, Mrs. W. M. 5039 W. 13th
 Brubaker, Mrs. E. H. 624 E. 23rd

Burdette, Mrs. H. F.
 1503 N. Penn., No. 701

Burkhardt, Mrs. Boyd
 328 N. West Tipton

Burney, Mrs. Leroy E.
 321 Blue Ridge Rd

Cahal, Mrs. E. E. 27 E. 39th

Cahn, Mrs. Hugh W. 3039 Park

Call, Mrs. Herbert F. 710 E. 57th

Calvy, Mrs. Wm. J. 4631 E. 34th

Carson, Mrs. E. Wayne

7177 N. Meridian

Clark, Mrs. Lawson J.

2425 E. Kessler Blvd.

Close, Mrs. D. W. 403 W. 49th

Coble, Mrs. R. R. 5530 Central

Conley, Mrs. J. L. 1617 E. Ohio

Conway, Mrs. Glen

2235 E. Garfield Dr.

Cornacchione, Mrs. M.

5703 Broadway Terrace

Cortese, Mrs. T. A. 3240 Brill Rd.

Cox, Mrs. C. E. R. 16, Box 593

Crawford, Mrs. J. A. 920 E. 40th

Culbertson, Mrs. C. G. 6060 Park

Culloden, Mrs. W. G. 203 E. 47th

Cuthbert, Mrs. Marvin

5611 N. Delaware

Dalton, Mrs. John. 5245 Kenwood

Davidson, Mrs. N. Cort

3135 N. Delaware

Davis, Mrs. Sam S. 5114 Park

Day, Mrs. Clark. 29 W. 42nd

DeArmond, Mrs. Albert M.

5401 N. Delaware

Dearmin, Mrs. Robert M.

5147 N. Delaware

Deever, Mrs. J. W. 4160 Madison

Dimond, Mrs. E. G. 39 E. 9th

Donato, Mrs. A. M. 4225 S. East

Dorman, Mrs. W. Leland

R. R. 9, Box 157

Dugan, Mrs. Wm. M.

5747 Rolling Ridge Rd.

Dunbar, Mrs. C. V. 3615 Watson

Dyar, Mrs. E. W. 5407 Kenwood

Eastman, Mrs. Jos. R.

8160 N. Meridian

Eaton, Mrs. E. R. 2312 Brookside

Eberwein, Mrs. John H.

414 E. Fall Creek Pkwy., N. D.

Eckert, Mrs. R. A. 8½ Johnson

Eicher, Mrs. Palmer. 4902 Park

Eldridge, Mrs. G. E. 3839 Central

Ellis, Mrs. Bert E. 547 E. 36th

Emhardt, Mrs. J. T. 2957 S. East

Emhardt, Mrs. John Wm.

5424 Washington Blvd.

Ernst, Mrs. C. E. 3206 N. Sharon

Everly, Mrs. Ralph V. 1105 E. 58th

Fausset, Mrs. C. B. 5236 Graceland

Ferguson, Mrs. Wm. B.

535 Winona Village

Fisher, Mrs. J. E. 717 W. 44th

Flick, Mrs. J. J. 3021 N. Sharon

Flora, Mrs. J. O. 328 Barton

Folkening, Mrs. Norval C.

1301 Woodlawn

Foreman, Mrs. Harry Lee

3835 Washington Blvd.

Fosler, Mrs. David W.

5718 N. Delaware

Fouts, Mrs. P. J. 4903 N. Capitol

Fromhold, Mrs. W. A. 5514 Manker

Gabe, Mrs. Wm. E.

502 W. Hampton Dr.

MARION COUNTY

(Indianapolis—Continued)

Gaddy, Mrs. Euclid T.
5624 Washington Blvd.

Gambill, Mrs. Wm. Dudley
1911 Kessler Blvd., N. D.

Gammieri, Mrs. P. . . . 4453 Guilford

Garber, Mrs. J. N. . . . 4535 Marcy La.

Garceau, Mrs. G. J. . . 4334 N. Penn.

Gardner, Mrs. Buckman
3007 E. 39th, Apt. 59

Gardiner, Mrs. S. H. . . 46 W. 52nd

Garrett, Mrs. J. D. 4650 N. Illinois

Garrett, Mrs. Robert A.
5022 Winthrop

Gastineau, Mrs. Frank M.
5344 N. Penn.

Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy.

George, Mrs. Chas. . . 1121 E. 80th

Gifford, Mrs. Fred E.
5125 N. Meridian

Gillespie, Mrs. C. F. . 2615 E. 35th

Goldman, Mrs. Samuel
5632 Rosslyn

Gosman, Mrs. Jas. H. . . 340 Maple

Gramling, Mrs. Joseph J.
5550 N. Pennsylvania

Graves, Mrs. John W.
949 Ellenberger Pkwy., E. D.

Greist, Mrs. John H. . . . 5032 Park

Griffith, Mrs. Ross E. . 4804 Bdwy.

Grissell, Mrs. T. L. 3273 Winthrop

Groves, Mrs. E. G.
242 W. Bdwy., Shelbyville, Ind.

Gustafson, Mrs. Gerald W.
5768 N. Pennsylvania

Habich, Mrs. Carl. . . . 4335 Bdwy.

Hadley, Mrs. David
3132 N. New Jersey

Haggard, Mrs. Edmund B.
3481 Birchwood

Hahn, Mrs. E. V. . . R. 2, Box 529

Hall, Mrs. Frank . . . 6969 College

Hall, Mrs. Jack R. . . 3542 Kenwood

Hamer, Mrs. H. G. 5340 N. Illinois

Hampshire, Mrs. D. . . 4378 Central

Hanna, Mrs. T. A. . . . 5009 W. 15th

Hansell, Mrs. Robert M.
3525 N. Gladstone

Harcourt, Mrs. Allen K.
4915 N. Illinois

Harding, Mrs. M. S. . . 46 W. 46th

Harold, Mrs. Albert H.
R. R. 13, Box 389

Harold, Mrs. N. E. . . . 653 W. 30th

Harris, Mrs. C. B. R. 16, Box 575

Haslinger, Mrs. C. J.
5236 Boulevard Place

Hawk, Mrs. J. H. . . . 4249 Bdwy.

Hays, Mrs. E. L. . . . 2607 Manker

Hedrick, Mrs. Philip . . 652 E. 54th

Helmer, Mrs. O. M. 5015 N. Illinois

Hendricks, Mrs. John W.
124 W. 64th St.

Hepburn, Mrs. Charles K.
7210 Williams Creek Dr.

Hetherington, Mrs. A. M.
5224 Pleasant Run Blvd.

Heubi, Mrs. J. E. . . . 5061 N. Illinois

Hickman, Mrs. W. E. 5125 N. Penn.

Hippensteel, Mrs. Russell
3540 N. Meridian

Hoag, Mrs. W. I. . . . 2627 W. Wash.

Holman, Mrs. Jerome E., Sr.
4503 E. Kessler Blvd.

Holman, Mrs. Jerome E., Jr.
5359 Guilford

Hood, Mrs. A. A. . . . 1444 W. 25th

Howell, Mrs. R. D. . . . 930 E. 56th

Hudson, Mrs. Foster J.
525 W. Hampton Dr.

Hughes, Mrs. J. E. 1628 Carrollton

Hughes, Mrs. Wm. F., Sr.
4025 N. Meridian

Iske, Mrs. P. G. . . 3601 N. Meridian

Jaeger, Mrs. Alfred S.
2935 Washington Blvd.

Jay, Mrs. Arthur N.
4319 Kingsley Dr.

Jennings, Mrs. Frank L.
Sunnyside San., Oaklandon

Jewett, Mrs. J. H. . . . 4907 Rosslyn

Jinks, Mrs. C. H. . . 5740 Carrollton

Johnson, Mrs. T. W. . . 5311 Bdwy.

Jones, Mrs. D. E. . . 646 Berkley Rd.

Jones, Mrs. George L. Wanamaker

Katterjohn, Mrs. Jas. . . 102 E. 50th

Keenan, Mrs. Reid L.
3702 N. Delaware

Keiser, Mrs. Venice D.
5769 Broadway

Kelly, Mrs. J. F. . . 5464 N. Capitol

Kelly, Mrs. Walter F.
6845 E. Pleasant Run Pkwy.

Kelly, Mrs. W. M. . . 3308 N. Euclid

Kempf, Mrs. Gerald F.
2605 E. Riverside Dr.

Kennedy, Mrs. H. F. 757 N. Bolton

Kerr, Mrs. Harry R. . . 5774 Wash.

Kilgore, Mrs. B. W.
3351 N. Wallace

Kime, Mrs. Edwin N.
239 Buckingham Drive

Kingsbury, Mrs. J. K. 5776 E. Mich.

Kirklín, Mrs. O. L. . . 1500 E. 80th

Kiser, Mrs. Edgar F.
3715 Washington Blvd.

Kitterman, Mrs. Harry E.
5108 Graceland

Knowles, Mrs. C. Y.
1121 N. Downey

Kohlstaedt, Mrs. K. G. 645 E. 80th

Koons, Mrs. K. M. . . 5767 N. Penn.

Kopp, Mrs. H. S. 3710 N. Colorado

Kornafel, Mrs. L. H. . 6201 College

Kraft, Mrs. Bennett . . 7025 Wash.

Kuntz, Mrs. Herman W.
823 Weghorst

Kurtz, Mrs. Philip L. . 3866 Byram

LaDine, Mrs. C. B. . . 4221 E. 35th

Lamb, Mrs. Emmett B.
1180 Golden Hill Drive

Lamb, Mrs. R. W. . . 4626 N. Capitol

Lamber, Mrs. Chet K.
1434 N. Delaware

Larkin, Mrs. Bernard
3103 N. Meridian

Lawler, Mrs. George F.
5610 E. St. Clair

Leasure, Mrs. J. Kent
5831 Washington Blvd.

Leonard, Mrs. Henry S.
3916 Washington Blvd.

Levi, Mrs. Leon. . . 402 W. Hampton

Lewis, Mrs. R. J. . . . 3742 N. Denny

Lichtenburg, Mrs. Melvin
4021 N. New Jersey

Lidikay, Mrs. E. C. 5822 N. Oxford

Link, Mrs. Goethe
3015 N. Meridian

Link, Mrs. W. H. . . . 1445 Broadway

Littell, Mrs. J. J. . . . 3121 N. Penn.

Lochry, Mrs. Ralph L.
6150 Crows Nest Drive

Loehr, Mrs. W. M. 6044 Crittenden

Lomax, Mrs. C. C. . . . 2017 E. 52nd

Lord, Mrs. Glenn C.
4455 Washington Blvd.

Lukenbill, Mrs. E. . . 6450 Broadway

Lybrook, Mrs. Wm. B.
3636 N. Keystone

MacDonald, Mrs. John A.
1408 N. Penn.

MacGregor, Mrs. Donald E.
6080 N. Michigan Rd.

McBride, Mrs. J. S. . . 3641 Watson

McCaskey, Mrs. Carl H.
3545 Washington Blvd.

McCormick, Mrs. C. O.
4041 Washington Blvd.

McCormick, Mrs. C. O., Jr.
3715 College

McDevitt, Mrs. D. R. 5470 Guilford

McQuiston, Mrs. Ralph J.
R. R. No. 15, Box 385

McTurnan, Mrs. Robert W.
410 N. Meridian

Maly, Mrs. Charles H.
3542 N. Gladstone

Manion, Mrs. Marlow W.
5132 N. New Jersey

Mann, Mrs. Mortimer . . 28 E. 55th

Marshall, Mrs. A. L. 3914 Guilford

Marshall, Mrs. Cavins R.
6120 N. Michigan Rd.

Martin, Mrs. L. H. . . . 5069 W. 15th

Martz, Mrs. Carl D.
4571 Fall Creek Blvd., S. D.

Masters, Mrs. J. B. 3350 Carrollton

Masters, Mrs. John M. . 34 E. 46th

Matthew, Mrs. W. Burleigh
3462 E. Fall Creek Blvd.

Meiks, Mrs. L. T. . . . 4203 N. Penn.

Mericle, Mrs. Earl W.
4480 N. Meridian

Merrell, Mrs. Paul
270 Buckingham Dr.

Mertz, Mrs. H. O. . . . Brendonwood

Micheli, Mrs. Arthur J.
3453 N. Pennsylvania

Miller, Mrs. R. S. . . . 6140 College

Miller, Mrs. Ray D. . . 3960 Central

Mitchell, Mrs. Earl H. . 1023 King

Molt, Mrs. William F.
2315 N. Talbott

Montgomery, Mrs. W. F.
246 W. 54th

Moore, Mrs. B. B. . . 5005 N. Illinois

Moore, Mrs. H. T. R. 17, Box 731

Moore, Mrs. Robert M.
5617 N. Meridian

Morrison, Mrs. L. E. 3460 Winthrop

Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd.

Moser, Mrs. R. H. 6220 Sunset La.

Myers, Mrs. Roy V. 4723 Broadway

Nafe, Mrs. Cleon A.
5060 N. Meridian

Nay, Mrs. Richard M. . 4163 Park

MARION COUNTY

(Indianapolis—Continued)

Need, Mrs. L. T. . . . R. 19, Box 562
 Nehil, Mrs. Lawrence W.
 257 W. Westfield Blvd.
 Nie, Mrs. L. W. 4815 Guilford
 Noble, Mrs. Thomas B., Jr.
 4360 N. Pennsylvania
 Neier, Mrs. O. C. . . . 5506 University
 Nolting, Mrs. Henry F.
 155 W. Hampton Dr.
 Nonte, Mrs. L. R. . . . 4525 Marcy La.
 Norman, Mrs. O. B. . . 3645 Winthrop
 Nourse, Mrs. M. 5251 Primrose
 Nugent, Mrs. E. 2266 Wyndale Rd.
 Olvey, Mrs. O. N. . . . 5533 Broadway
 Otten, Mrs. C. F. 4456 Central
 Ottinger, Mrs. Ross C.
 5720 Sunset Lane
 Palmer, Mrs. R. R. . . . 2439 Madison
 Pandolfo, Mrs. H. . . . 529 Markwood
 Patton, Mrs. Martin T.
 3060 N. Meridian
 Paulissen, Mrs. G. T. . . 310 E. 24th
 Paynter, Mrs. Morris B.
 Roberts Road, Southport
 Pearson, Mrs. Lyman R.
 5338 Washington Blvd.
 Peirce, Mrs. James D.
 3272 N. Winthrop
 Pennington, Mrs. Walter E.
 4420 N. Meridian
 Permer, Mrs. E. 3018 N. Delaware
 Peters, Mrs. R. J. . . . 3203 E. Michigan
 Pfaff, Mrs. O. G. 4605 N. Meridian
 Pollak, Mrs. Lewis . . . 5658 Guilford
 Raber, Mrs. R. M. 419 E. 48th
 Ramage, Mrs. Walter F.
 244 S. First, Beech Grove
 Ramsey, Mrs. F. B. . . . 325 E. 36th
 Reed, Mrs. P. B. 1834 E. 10th
 Rees, Mrs. R. C. 18 N. Campbell
 Reid, Mrs. Charles A.
 R. R. No. 1, Box 404
 Reiss, Mrs. Jack 5230 Park
 Rice, Mrs. Thurman B.
 3167 N. Delaware
 Ricketts, Mrs. Joseph W.
 5349 Kenwood
 Rigg, Mrs. J. F. 5115 N. Meridian
 Rinne, Mrs. John I., Jr.
 3608 N. Gladstone
 Ritchey, Mrs. James O. . 43 W. 43rd
 Robb, Mrs. John A. . . . 5254 Broadway
 Roller, Mrs. C. W. . . . 2301 Garfield Dr.
 Rosenak, Mrs. B. D. . . . 325 E. 45th
 Rosenbaum, Mrs. Irving
 1836 E. Kessler Blvd.
 Ross, Mrs. Alexander T.
 265 W. Westfield Blvd.
 Row, Mrs. D. H.
 5214 Grandview Dr.
 Ruddell, Mrs. Karl R.
 2626 N. Meridian
 Rupel, Mrs. Ernest . . . 5716 N. Penn.
 Rust, Mrs. Byron K.
 R. R. No. 14, Box 214
 Ryan, Mrs. Glenn V.
 3168 E. Fall Creek Pkwy.
 Sage, Mrs. Russell A. . . 8650 College
 Salb, Mrs. Max C. 1116 N. Penn.
 Sandy, Mrs. Wm. A. . . . 3227 Park
 Scamahorn, M. O. Pittsboro
 Scamahorn, Mrs. O. T. . . Pittsboro

Schneider, Mrs. Carl J.
 1426 N. LaSalle
 Schuchman, Mrs. G. . . . 5837 College
 Shafer, Mrs. Marion R.
 6390 Allisonville Road
 Shimer, Mrs. Will
 2152 N. Meridian, No. 105
 Shipley, Mrs. R. E. . . . 206 E. 46th
 Shugart, Mrs. J. A. . . . 2620 E. 37th
 Shumacker, Mrs. H. B. . 404 E. 43rd
 Shuster, Mrs. Dwight . . 612 N. Denny
 Sicks, Mrs. Okla. 5609 N. Penn.
 Siersdorfer, Mrs. T. N.
 6003 W. Washington
 Sigmond, Mrs. Harvey W.
 3245 N. Pennsylvania
 Sims, Mrs. J. L. 3723 N. Gale
 Sluss, Mrs. David
 3657 Washington Blvd.
 Smiley, Mrs. James H.
 4201 E. Michigan
 Smith, Mrs. D. L. 3433 Central
 Smith, Mrs. L. A. 126 Berkley
 Smith, Mrs. Roy Lee
 R. R. 6, Box 540-B
 Solomon, Mrs. R. A. . . . 5330 N. Penn.
 Sovine, Mrs. J. W. . . . 5311 N. Illinois
 Spahr, Mrs. John F., Jr.
 3845 N. Meridian
 Spaulding, Mrs. J. J.
 4207 N. Capitol Ave.
 Spivey, Mrs. R. J. . . . New Augusta
 Sputh, Mrs. Carl B., Jr.
 3662 N. Gale
 Sputh, Mrs. Carl B., Sr.
 5735 Central Ave.
 Stanley, Mrs. John
 3146 Washington Blvd.
 Steele, Mrs. P. W. 2035 N. Meridian
 Stephens, Mrs. K. H. . . . Lawrence
 Stevens, Mrs. S. L. . . . 3430 N. Temple
 Stoelting, Mrs. V. 3608 N. Chester
 Stone, Mrs. A. T. 3337 Carrollton
 Stone, Mrs. D. F. 4017 Clarendon
 Stucky, Mrs. E. K. 3602 Watson
 Sudranski, Mrs. Herbert F.
 1701 N. Illinois
 Swan, Mrs. John R.
 5402 N. Delaware
 Talbott, Mrs. D. E. . . . 5906 Rosslyn
 Tanner, Mrs. Henry S.
 5144 N. Delaware
 Taylor, Mrs. Clifford C.
 5938 Crittenden
 Taylor, Mrs. Frederic . . 40 E. 43rd
 Teague, Mrs. Frank W.
 R. R. 14, Box 216
 Terry, Mrs. W. B. G., Jr.
 3896 N. Sherman
 Tether, Mrs. Joseph E.
 R. R. No. 18, Box 226
 Tharpe, Mrs. Ray Marott Hotel
 Thatcher, Mrs. Hugh K., Jr.
 745 W. 44th
 Thomas, Mrs. L. 4643 N. Capitol
 Thomas, Mrs. Morris E.
 5207 N. New Jersey
 Thompson, Mrs. Charles F.
 6038 N. Olney
 Thompson, Mrs. John V.
 3502 N. Wallace
 Thornburg, Mrs. Kenneth E.
 4416 Carrollton
 Thurston, Mrs. A. L. . . . 421 E. 41st
 Tinney, Mrs. W. E. . . . 3902 Carrollton

Tinsley, Mrs. W. B. . . . 3314 Carrollton
 Torrella, Mrs. J. A. . . . 4918 W. 14th
 Toumey, Mrs. F. L.
 4450 Marcy Lane, No. 109
 Travis, Mrs. J. C. 6268 Broadway
 Trusler, Mrs. Harold M.
 6150 N. Pennsylvania
 Tuchman, Mrs. J. H. . . 4525 Indianola
 Tucker, Mrs. W. S. . . . 5421 Indianola
 Vandivier, Mrs. R. M.
 4732 Cornelius
 VanMeter, Mrs. C. Powell
 1925 N. Emerson
 VanOsdol, Mrs. Harry A.
 43 Hampton Dr.
 Voyles, Mrs. C. F. . . . 4150 N. Meridian
 Waldo, Mrs. J. T. 8383 N. Illinois
 Walker, Mrs. F. C. . . . 5563 N. Penn.
 Walker, Mrs. G. W. . . . 5959 E. 42nd
 Waller, Mrs. Jno. 5242 N. Illinois
 Walther, Mrs. J. E. . . . 3641 Watson
 Ward, Mrs. W. C. 126 E. 48th
 Warvel, Mrs. J. H. R. . . 17, Bx. 275
 Weller, Mrs. Chas. A.
 3720 N. Delaware
 Westfall, Mrs. B. K., Jr.,
 6601 College
 Westfall, Mrs. J. B. . . . 3618 E. 34th
 White, Mrs. D. J. 5430 N. Delaware
 Whitehead, Mrs. John M.
 2201 Nowland
 Wilkens, Mrs. Irvin W.
 4816 Pleasant Run Pkwy.
 Williams, Mrs. H. S., Jr.
 5105 Indianola
 Wilson, Mrs. O. R. 512 E. 28th
 Winters, Mrs. Matthew
 4044 Carrollton
 Wise, Mrs. Wm. 4934 N. Penn.
 Wishard, Mrs. W. N.
 4150 N. Illinois
 Wolfram, Mrs. Don J.
 5872 Broadway
 Wood, Mrs. George
 5122 Washington Blvd.
 Woodard, Mrs. A. S., Jr.
 5449 N. Penn.
 Wright, Mrs. J. M. . . . 2110 W. 42nd
 Wytenbach, Mrs. F. C.
 R. R. 2, Brownsburg
 Wytenbach, Mrs. John E.
 5509 Kenwood
 Young, Mrs. J. W. 5815 Primrose
 Young, Mrs. J. M. 4325 Marcy Lane
 Young, Mrs. W. G. 6601 E. 42nd St.

MARSHALL COUNTY

McCracken, Mrs. H. M. . . . Argos
 Sheller, Mrs. Tom G. Argos
 Bowen, Mrs. Otis Bremen
 Cripe, Mrs. Earl P. Bremen
 Schriener, Mrs. John Bremen
 Graham, Mrs. C. R. Bourbon

Culver

Mackey, Mrs. C. G. 217 Ohio
 Urschel, Mrs. Dan Mentone

Plymouth

Eley, Mrs. T. C. 801 N. Michigan
 Klingler, Mrs. M. O.

1111 Ferndale

MARSHALL COUNTY

(Continued)

Pomeroy, Mrs. R. K. . . . 1400 Park
 Stephens, Mrs. R. C. . . . 919 N. Mich.
 Tripp, Mrs. H. D. . . . 702 N. Center
 Vore, Mrs. L. W. . . . 1301 N. Mich.

MIAMI COUNTY

Line, Mrs. Homer.Chili
 Frybarger, Mrs. S. S. . . . Converse
 Sennett, Mrs. W. K.Macy
 Waite, Miss Margret.Macy
 Rendel, Mrs. H. E.Mexico

Peru

Baldwin, Mrs. C. A. . . . 36 W. 6th
 Barnett, Helen65 N. Miami
 Berkebile, Mrs. J. B. . . . 15 W. 6th
 Carl, Mrs. Omer.128 W. 3rd
 Eikenberry, Mrs. B. F. . . . 28 W. 6th
 Ewing, Miss Ethel.Dukes Hosp.
 Freezee, Mrs. J. A. . . . 212 E. Main
 Lynn, Mrs. F. M.258 W. Main
 Malouf, Mrs. S. D.359 W. 3rd
 Wildman, Mrs. R. E.R. R. 2
 Yarling, Mrs. Francis. . . . 117 E. 5th
 McDowell, Mrs. M. A. . . . 53 E. 2nd

MONTGOMERY COUNTY

Stout, Mrs. Harry.Colfax

Crawfordsville

Alexander, Mrs. S. J. . . . 202 West
 Ball, Mrs. T. Z. . . . 401 S. Washington
 Burks, Mrs. Jess E. . . . 411 S. Walnut
 Cooksey, Mrs. T. L. . . . 206 Marshall
 Cornell, Mrs. R. A. . . . 521½ E. Main
 Daugherty, Mrs. F. N. . . . 415 W. Main
 Echternacht, Mrs. A. P. . . . R. R. 4
 Griffith, Mrs. J. B. . . . 218 S. Green
 Haller, Mrs. T. C. . . . 508 W. Main
 Humphreys, Mrs. John W.

206 Woodlawn Pl.

Kinnaman, Mrs. H. A.

1107 W. Wabash

Kirtley, Mrs. J. M. . . . 201 S. Grant
 Lingeman, Mrs. B. J. . . . 203 Wallace
 Millis, Mrs. R. J.8 Mills Pl.
 Mount, Mrs. W. M. . . . 1417 W. Main
 Pierson, Mrs. R. H. . . . 305 E. Main
 Peacock, Mrs. F. N. . . . 107 Vernon
 Peacock, Mrs. Nell. . . . 410 E. Wabash
 Pollom, Mrs. R. R. . . . 306 E. Water
 Sharp, Mrs. J. L. . . . 1403 E. Main
 Taylor, Mrs. W. M. . . . 410 S. Water
 Wallace, Mrs. H. C.

107 W. Jefferson

Otten, Mrs. R. E.Darlington
 Schaaf, Mrs. Alvin. . . . Jamestown
 Smith, Mrs. J. B.Kingman
 Blix, Mrs. Fred.Ladoga
 Denny, Mrs. F. T.Ladoga
 Walterhouse, Mrs. H. K. . . . Ladoga
 Erk, Mrs. V. O.Linden
 Kindell, Mrs. H. D. . . . New Richmond
 Gwaltney, Mrs. L. F. . . . Roachdale
 Richards, Mrs. E. E. . . . Russellville
 Himebaugh, Mrs. C. J.

Veedersburg

Rusk, Mrs. H. M.Wallace
 Johnson, Mrs. Dale. . . . Waynetown
 Parker, Mrs. C. B.Wingate

MORGAN COUNTY

Comer, Mrs. Chas.Mooreville
 Comer, Mrs. Kenneth. . . . Mooreville
 Van Bokkelen, Mrs. R. W.
 Mooreville

Martinsville

Dickens, Mrs. K. L.
 Eisenberg, Mrs. David
 Farr, Mrs. James C.
 Gray, Mrs. Leon.260 N. Ohio
 Pitkin, Mrs. E. M. . . . 309 E. Wash.
 Pitkin, Mrs. M. C. . . . 440 E. Wash.
 Sweet, Mrs. Austin
 Willian, Mrs. H. R.

NORTHEASTERN DISTRICT

Nash, Mrs. J. R.Albion
 Covell, Mrs. H. M.Auburn
 Nugen, Mrs. Harold. . . . Auburn
 Wills, Mrs. Max.Auburn
 Hathaway, Mrs. C. B. . . . Butler
 Jinnings, Mrs. L. E. . . . Garrett
 Kantzer, Mrs. F. B. . . . Garrett
 Reynolds, Mrs. Perry. . . . Garrett
 Alford, Mrs. James. . . . Hamilton
 Bryan, Mrs. F. C. . . . Kendallville
 Gutstein, Mrs. R. R. . . . Kendallville
 Hardy, Mrs. F. C. . . . Kendallville
 Lawson, Mrs. I. H. . . . Kendallville
 Mettler, Mrs. D. C. . . . Kendallville
 Munk, Mrs. C. E. . . . Kendallville
 Seybert, Mrs. J. D. . . . Kendallville
 Williams, Mrs. H. O. . . . Kendallville
 Stultz, Mrs. Q. F. . . . Ligonier
 Fipp, Mrs. A. L.Rome City
 Coleman, Mrs. Floyd. . . . Waterloo
 Luckey, Mrs. J. E. . . . Wolf Lake
 Luckey, Mrs. R. C. . . . Wolf Lake

OWEN-MONROE COUNTY

Bloomington

Austin, Mrs. Rayborn. . . 114 S. Grant
 Baxter, Mrs. Neal. . . . 515 N. Wash.
 Borland, Mrs. Ray. . . . Moores Pike
 Boulware, Mrs. J. P. . . 412 S. High
 Buckingham, Mrs. Richd. . 705 S. St.
 Geiger, Mrs. D. N. . . . N. Fee Lane
 Holland, Mrs. Chas. . . . 712 N. Wash.
 Holland, Mrs. Frank. . . 514 N. College
 Holland, Mrs. D. J. . . . 313 N. College
 Holland, Mrs. J. E. P. . . 801 E. 8th
 Holland, Mrs. Phillip

514 N. College

Karsell, Mrs. Wm. . . . 1401 E. 10th
 Marchant, Mrs. Clarence

350 S. College

Myers, Mrs. B. D. . . . 424 N. Walnut
 Prosser, Mrs. Wm. . . . 1211 Maxwell
 Ramsey, Mrs. Hugh. . . 619 E. First
 Reed, Mrs. Wm.1215 Atwater
 Rogers, Mrs. Floyd. . . . 804 E. 8th
 Ross, Mrs. Ben. . . . Martinsville Rd.
 Schell, Mrs. H. D. . . . 801 E. 7th
 Smith, Mrs. Herschel

Martinsville Rd.

Spencer, Mrs. Beaufort. . 816 E. 8th
 Thomas, Mrs. H. B. . . . 1717 E. 3rd
 Topologus, Mrs. Jas. . . 603 N. Walnut
 Stangle, Mrs. Wm. . . . Nashville Rd.
 Wilson, Mrs. T. L. . . . 110 N. Lincoln
 Stouder, Mrs. Chas. E. . . Gosport
 Smith, Mrs. Paul. . . . Ellettsville
 Mitchell, Mrs. Geo. L. . . Smithville
 Brown, Mrs. Marcel S. . . Spencer
 Green, Mrs. C. D.Spencer
 Smith, Mrs. F. R.Spencer

PERRY COUNTY

Cannelton

Bush, Mrs. Hargis.6th St.

Tell City

Coultas, Mrs. P. J.809 Main
 Dome, Mrs. Hardin. . . . 147 11th
 Dukes, Mrs. David A. . . . 521 Main
 Glenn, Mrs. Fred C. . . . 436 Main
 James, Mrs. Nick A.740 9th
 Lashley, Mrs. D. L.600 9th
 Lally, Mrs. Bernard. . . . Main St.
 Neifert, Mrs. Noel L. . . . 11th St.
 Snyder, Mrs. Earl.Troy

PORTER COUNTY

Chesterton

Griffin, Mrs. Jos. F.134 Park
 Hall, Mrs. Thos. C. . . . 600 E. Morgan

Valparaiso

Brown, Mrs. J. C.458 Park
 Davis, Mrs. Carl E. . . . 202 Indiana
 DeGrazia, Mrs. E. G. . . . 157 McIntyre
 DeWitt, Mrs. C. H. . . . 836 LaPorte
 Douglas, Mrs. G. R. . . . 404 Wash.
 Eades, Mrs. Ralph

501 E. Lincolnway

LaRocca, Mrs. Jos.402 Erie
 Makovsky, Mrs. Theodore

909 Institute

Powell, Mrs. E. H. . . . Flint Lake Rd.
 Miller, Mrs. E. H.608 Union
 Seipel, Mrs. H. O. . . . 302 Lafayette
 Stoner, Mrs. G. H. . . . Flint Lake Rd.
 Vietzke, Mrs. J. P. . . . 58 Jefferson
 Van Winkle, Mrs. A. J. . . 102 Jefferson

RUSH COUNTY

McNabb, Mrs. G. B. . . . Carthage
 Worth, Mrs. C. W.Milroy

Rushville

Anderson, Mrs. Sam. . . 914 N. Morgan
 Atkins, Mrs. C. C. . . . 410 N. Perkins
 Corpe, Mrs. K. F.R. R. 4
 Dean, Mrs. D. I.310 E. 5th
 Denny, Mrs. M. H. . . . 124 E. 12th
 Frazier, Mrs. J. R. . . . 210 E. 7th
 Green, Mrs. F. H. . . . 322 W. 8th
 Johnson, Mrs. R. B.

841 N. Harrison

Kennedy, Mrs. R. O. . . 1004 N. Main
 Lee, Mrs. Jno. M. . . . 914 N. Morgan
 Nutter, Mrs. W. H. . . 1003 N. Morgan
 Shanks, Mrs. R. E. . . 1110 N. Morgan
 Kiplinger, Mrs. John. . 832 N. Main
 Morgan, Mrs. Helen. . 327 N. Morgan
 Sipe, Anna.222 W. 3rd
 Smullen, Bertha.R. R. 3

ST. JOSEPH COUNTY

Mishawaka

Bassler, Mrs. C. R. . . . 206 S. Main
 Christophel, Dr. Verna

834 Lincolnway E.

Ellison, Mrs. Alfred. . . Dragon Trail
 Ganser, Mrs. Robt. . . . 409 E. 3rd
 Goethals, Mrs. J. C.

602 Lincolnway W.

Joest, Mrs. Chas. . . . 332 N. Wenger
 Kamm, Mrs. B. A.

618 Lincolnway W.

Logan, Mrs. F. W.

304 Lincolnway E.

Nelson, Mrs. F. D. . . . 138 River
 McDonald, Mrs. R. M. . . E. Jefferson

ST. JOSEPH COUNTY

(Mishawaka—Continued)

Orr, Mrs. W. Robt. . . . 124 S. Race
 Parker, Mrs. Earl. . . . 802 W. Bartel
 Proudfit, Mrs. C. H. . . . 1135 E. 3rd
 Rosenwasser, Mrs. Jacob
 415 Indiana
 Sirlin, Mrs. E. M.
 419 Lincolnway W.
 Spalding, Mrs. Wendell
 617 Webster
 Templeton, Mrs. Ames
 914 W. Lawrence
 Walters, Mrs. Chas. E. . . 1115 Cedar
 Ward, Mrs. Jas. . 316 Lincolnway E.
 Whitlock, Mrs. Merle. 2530 Riviera
 Wixted, Dr. Julia
 1009 Lincolnway E.
 Wurster, Mrs. H. C. . . . 221 E. 3rd
 Wygant, Mrs. M. D. . . . 5636 Terry
 Wyland, Mrs. B. J. . . . 510 Calhoun
 Zimmer, Mrs. H. J. . 333 Edgewater

South Bend

Acker, Mrs. Robt. . . . 2719 Marine
 Arisman, Mrs. R. K. . 1615 E. Colfax
 Baker, Mrs. Walter. . . 128 S. Scott
 Balla, Mrs. Morris. 1516 E. Wayne
 Bechtold, Mrs. S. E. . . 1820 Wilber
 Bennett, Mrs. J. R. . 1072 Woodward
 Biassini, Mrs. B. A.
 403 Dixie Highway, N.
 Bickel, Mrs. David. 1335 E. Wayne
 Birmingham, Mrs. P. J.
 1126 E. Irvington
 Bishop, Mrs. C. A. . . . 1301 Garland
 Bixler, Mrs. Louis. . 506 E. Altgelo
 Blackburn, Mrs. Erwin
 1343 E. LaSalle
 Bodnar, Mrs. L. M. . . 1515 Virginia
 Bosenbury, Mrs. Charles
 323 W. Navarre
 Bryan, Mrs. Robt. . . . 519 Harrison
 Buechner, Mrs. Fred. 603 W. Marion
 Bussard, Mrs. C. F. . 329 W. Madison
 Bussard, Mrs. F. W. . 1332 E. Monroe
 Braunsdorf, Mrs. Robert
 1209 Belmont
 Buchanan, Mrs. Wallace
 1351 E. South
 Carter, Mrs. F. R. N.
 2000 E. Jefferson
 Cassidy, Mrs. J. V. . . 110 Napoleon
 Caton, Mrs. Jos. . . . 1123 N. Niles
 Chambers, Mrs. Wm. . 1335 E. South
 Clark, Mrs. W. H. . 541 N. Ironwood
 Clark, Mrs. Stanley
 1242 E. Jefferson
 Clapp, Mrs. Fred. . . . 1432 S. Bend
 Colip, Mrs. George. . . . 300 David
 Condit, Mrs. D. H. . 1521 E. Wayne
 Cook, Mrs. Gordon. 1433 Mishawaka
 Custer, Mrs. E. W. . . . Laurel Rd.
 Dietl, Mrs. Ernest. 1427 N. O'Brien
 Donnelly, Mrs. Everett
 730 W. Indiana
 Duggan, Mrs. Jas. . . 110 Peachway
 Dunlap, Mrs. D. L. . . . 622 Park
 Edwards, Mrs. Bernard
 1341 E. Wayne
 Egan, Mrs. Sherman
 944 Riverside
 Ericksen, Mrs. L. G. 1322 E. Wayne

English, Mrs. Paul. . . . 1317 Wall
 Faltin, Mrs. L. . . . 302 S. Coquillard
 Feldman, Mrs. Max. . . 1021 Miami
 Firestein, Mrs. Ben. . 508 W. Colfax
 Fish, Mrs. C. M. . . . 119 Marquette
 Fish, Mrs. Edson. . . 1264 E. Colfax
 Fisher, Mrs. L. F. . . 1717 E. Colfax
 Filipek, Mrs. Walter
 2513 Lincolnway W.
 Frank, Mrs. L. L. . 534 N. Lafayette
 Frash, Mrs. D. W. . . 1235 E. Wayne
 Friedman, Mrs. Morris
 1420 E. Ewing
 Frith, Dr. Gladys. . . 521 W. Wash.
 Gates, Mrs. George
 411 W. North Shore Dr.
 Gilman, Mrs. Marcus
 2120 E. Jefferson
 Goraczewski, Mrs. T.
 1016 W. Washington
 Green, Mrs. George. 1515 E. Wayne
 Green, Mrs. Norval
 1631 Lincolnway W.
 Grillo, Mrs. Don. . . . 1832 N. Adams
 Giordano, Mrs. A. S. . 1222 25th St.
 Helmen, Mrs. Harry. 1428 E. Wash.
 Hewitt, Mrs. Marshall
 1702 Sunnymede
 Hilbert, Mrs. J. W. . . 410 W. Wash.
 Hillman, Mrs. Marion
 1516 Marquette
 Hillman, Mrs. W. H.
 1317 Marquette
 Holdeman, Dr. Lillian
 615 W. Colfax
 Hyde, Mrs. C. C. . . . 1521 E. Colfax
 Karn, Mrs. Jno. W. . . 425 Napoleon
 Klahr, Mrs. E. E. . . . 1422 McKinley
 Knode, Mrs. K. T. . . 101 E. N. Shore
 Langenbahn, Mrs. Carl
 1339 E. South
 Lindquist, Mrs. N. S. . 917 Blaine
 Liston, Mrs. Ann. . . 1111 Sunnymede
 Lane, Mrs. Wm. 845 Park
 Lang, Mrs. Jos. . . . 1710 E. LaSalle
 Lionberger, Mrs. John R.
 1136 Sunnymede
 Liss, Mrs. E. E. . . . 1612 E. Madison
 Ludwick, Mrs. H. A.
 3730 Lincolnway W.
 Mason, Mrs. Bernard . . 1013 Fox
 McCraley, Mrs. W. J. . 2420 Erskine
 McKenna, Mrs. H. J.
 1615 E. Wayne
 Metcalfe, Mrs. G. E.
 1209 E. Wayne
 Miller, Mrs. Milo. . . 1714 E. Madison
 Miller, Mrs. Wm. . . . 714 W. Wash.
 Murphy, Mrs. Eugene
 1411 Sunnymede
 Murphy, Dr. Josephine
 505 W. LaSalle
 Nelson, Mrs. Ray. 1340 Sunnymede
 Olson, Mrs. Kenneth. 226 Marquette
 Parke, Mrs. D. Davis. . 828 Sorin
 Pauszek, Mrs. T. B. . . 916 Riverside
 Petrass, Mrs. Andrew
 Liberty Highway
 Plain, Mrs. George. . 2280 Ponader
 Pyle, Mrs. Dale. . . 115 N. Sunnyside
 Rasmussen, Dr. Ruth F.
 120 N. Lafayette
 Rodin, Mrs. H. H. . 1119 Sunnymede
 Rosenheimer, Mrs. George
 1425 E. Woodside

Rubens, Mrs. Eli. . 1331 E. Victoria
 Rustin, Mrs. Edward. . 529 N. Main
 Rudolph, Mrs. Carl
 2016 E. Madison
 Sanderson, Mrs. R. B.
 1331 Sunnymede
 Sandock, Mrs. I. . . 310 S. Sunnyside
 Sandock, Mrs. Louis. 125 W. Marion
 Sandoz, Mrs. H. H.
 329 S. Hawthorne
 Sandoz, Mrs. Louis
 304 Twychenhan
 Savery, Mrs. Chas. . Ironwood Rd.
 Schiller, Mrs. Herbert A.
 1813 E. Cedar
 Selby, Mrs. K. E. . . 1327 E. Wayne
 Sennett, Mrs. C. M. . 1129 Belmont
 Sensenich, Mrs. R. L.
 120 W. LaSalle
 Seyler, Mrs. Paul G. . 810 S. Illinois
 Siebenthal, Mrs. B. J.
 2041 Hollywood
 Slominski, Mrs. H. H. . 1862 College
 Spenner, Mrs. Ray. 1909 E. Madison
 Stiver, Mrs. Dan. . . . 1329 Belmont
 Scott, Mrs. Frank. . . 1861 Adams
 Thornton, Mrs. M. J. . . Miami Rd.
 Traver, Mrs. P. C. . . 1010 Riverside
 Weiss, Mrs. Eugene. 2517 S. Mich.
 Wilhelm, Dr. Agatha. . 1121 Leeper
 Wilson, Mrs. James M.
 1403 E. Jefferson
 Bolka, Mrs. B. J. . Cassopolis, Mich.

SULLIVAN COUNTY

Brown, Mrs. Jno. S. . . . Carlisle
 Deputy, Mrs. F. M. . . . Dugger
 Dukes, Mrs. Fredk. M. . . Dugger
 O'Dell, Mrs. Harry C. . Farmersburg
 Oliphant, Mrs. J. T. . Farmersburg
 Zerfas, Mrs. L. G. . . . Merom

Sullivan

Bedwell, Mrs. M. H. . 345 W. Wash.
 Crowder, Mrs. J. R. . 241 W. Wash.
 Scott, Mrs. G. D. . . . 409 W. Wash.
 Scott, Mrs. I. H. . . . 330 W. Wash.

TIPPECANOE COUNTY

Lafayette

Clauser, Mrs. A. C. . . 2020 Union
 Dubois, Mrs. R. B. . . . 12 S. 30th
 Flack, Mrs. R. A. . . . 627 Central
 Gery, Mrs. Richd. . . 1507 Central
 Harter, Mrs. E. B. . . 1119 Adams
 Karberg, Mrs. R. S. . . 1600 Potomac
 Klepinger, Mrs. H. E. . 633 Central
 Loop, Mrs. F. A. . . . 633 Central
 McClelland, Mrs. Donald C.
 1021 Highland
 Miller, Mrs. Roland. . . 2055 S. 9th
 Morrison, Mrs. J. S. . . 422 N. 7th
 Neumann, Mrs. K. O. . 1410 S. 18th
 Pyke, Mrs. F. L. . . . 532 S. 9th
 Ratcliff, Mrs. F. W. . . 612 S. 28th
 Rothrock, Mrs. Phillip. 2061 S. 9th
 Stoen, Mrs. H. J. . . . 828 S. 11th
 Trout, Mrs. Carl J. . . . 1101 King
 Van Reed, Mrs. Earl. . . 806 S. 19th
 Waite, Mrs. R. R. . . . 117 S. 6th
 Washburn, Mrs. W. W. . 425 Asher

TIPPECANOE COUNTY

(Continued)

West Lafayette

Bayley, Mrs. Wm. E. 622 Rose
 Burkle, Mrs. J. C. 121 University
 Calvert, Mrs. R. R. 308 Park
 Cox, Mrs. Wayne. 349 Sylvia
 Engeler, Mrs. Jas. 315 W. Stadium
 Holladay, Mrs. L. B.
 227 S. Salisbury
 Loop, Mrs. Fredk. 303 Forest Hill
 McFadden, Mrs. James
 240 S. Chauncey
 Peyton, Mrs. Frank. 469 Vine
 Schuck, Miss Cecelia. 907 3rd
 Smith, Mrs. M. H. 1812 Garden
 Stahl, Mrs. Edw. T. 324 Park
 Sholty, Mrs. Wm. Elston
 McClure, Mrs. S. E. Monon
 Mitchell, Mrs. E. T. Romney
 Babb, Mrs. Forrest. Stockwell

VANDERBURGH COUNTY

Faith, Mrs. Ira L., Jr. Boonville
 Stover, Mrs. Wendell. Boonville
 Barrow, Mrs. John. Dale

Evansville

Acre, Mrs. Robt. R. 2311 Lincoln
 Adler, Mrs. Ray. 427 Lewis
 Allenbaugh, Mrs. A. E.
 3218 E. Mulberry
 Anderson, Mrs. Dwight W.
 805 E. Powell
 Antes, Mrs. Earl. 355 Dreier
 Austin, Mrs. Eugene
 2163 Bayard Park Dr.
 Baker, Mrs. H. M. Petersburg Rd.
 Barnhart, Mrs. Willard T.
 1211 Ravenswood
 Bennett, Mrs. Abner P.
 2507 E. Blackford
 Brockmole, Mrs. A. W. 700 Mary
 Brown, Mrs. Robt. L. 100 Mulberry
 Brown, Mrs. W. A. 1304 E. Gum
 Bryan, Mrs. Stanton
 3211 E. Mulberry
 Buchholz, Mrs. Ransom R.
 2812 Bellemeade
 Burnikel, Mrs. R. H. 217B Oak
 Cacia, Mrs. John. 2301 Vogel
 Caldwell, Mrs. Wm. C. 643 College
 Cockrum, Mrs. W. M. 1414 Parkside
 Cole, Mrs. Wm. L.
 1700 Bayard Pk. Dr.
 Combs, Mrs. H. T. R. R. 1, Box 561
 Conover, Mrs. Earl
 1930 Bayard Pk. Dr.
 Corcoran, Mrs. P. J. V. Plaza Dr.
 Crane, Mrs. A. L. Kratzville Rd.
 Crevello, Mrs. A. J. 957 E. Powell
 Crimm, Mrs. Paul. Boehne Hosp.
 Cullnane, Mrs. Chris W.
 3020 Mt. Vernon
 Daves, Mrs. W. L. 708 College
 Davidson, Mrs. W. D. 718 Blackford
 Dieckman, Mrs. Herbert
 Harrelton Ct.
 Denzer, Mrs. E. R. 1509 Southeast
 Denzer, Mrs. W. O. 923 Bellmeade
 Dodd, Mrs. R. K.
 New Green River Rd.
 Dycus, Mrs. Walter 3309 W. Mich.

Dyer, Mrs. Wallace K.
 502 S. E. Riverside Dr.
 Ehrich, Mrs. Wm. 1500 S. Kentucky
 Engel, Mrs. Edgar L. 852 E. Gum
 Faul, Mrs. Henry 7255 Willow Rd.
 Fickas, Mrs. Dallas. 913 Gum
 Fisher, Mrs. W. C. 529 Benninghof
 Fitzsimmons, Mrs. E. L.
 500 S. Boeke
 Flinn, Mrs. Jno. H. 452 Kenmore
 French, Mrs. W. C. Hoosier Ave.
 Fritsch, Mrs. L. E. 30 W. Franklin
 Gaul, Mrs. L. Edw. 508 S. Boeke
 Griep, Mrs. A. H.
 2024 Lincoln, No. A-1
 Goux, Mrs. Warren. 2410 N. Evans
 Hare, Mrs. Daniel. 3021 E. Powell
 Hare, Mrs. John H.
 Evansville State Hosp.
 Hart, Mrs. L. P. 910 E. Blackford
 Hartley, Mrs. C. A., Jr.
 1300 S. Kentucky
 Healy, Mrs. Wm. 722 S. Willow
 Hefti, Mrs. Karl. Eastridge Dr.
 Heinrich, Mrs. Weston
 2010 E. Chandler
 Helper, Mrs. Morton. 428 Ruston
 Herzer, Mrs. C. C. 2020 E. Mulberry
 Huggins, Mrs. Victor. 520 S. Alvord
 Hyatt, Mrs. G. T. 815 E. Chandler
 Johnson, Mrs. Gardner
 1412 Parkside Dr.
 Johnson, Mrs. Stephen L.
 750 S. Frederick
 Kerrigan, Mrs. Wm. F. 4314 Oak
 Kissler, Mrs. R. D. 1003 First
 Kiechle, Mrs. Frederick L.
 Boehne Hosp.
 Kleindorfer, Mrs. R. L.
 615 S. Willow
 Lang, Mrs. Shirley C.
 Outer Lincoln Ave.
 Lawrence, Mrs. Joseph C.
 1362 E. Chandler
 Leich, Mrs. Charles F.
 306 S. E. Riverside
 Leslie, Mrs. Ermil T. 2923 E. Gum
 Logan, Mrs. Jess. 503 First
 Lynch, Mrs. Paul V.
 216 S. E. Riverside
 Macer, Mrs. C. G. 2800 Penn.
 MacKenzie, Mrs. Pierce. 907 E. Gum
 McCool, Mrs. J. H. 920 E. Mulberry
 McDonald, Mrs. J. D. 317 Wabash
 Mehl, Mrs. Rudolph
 3103 Bellemeade
 Meyer, Mrs. K. T. 399 S. Alvord
 Miller, Mrs. L. B. 417 S. Kelsay
 Miller, Mrs. Milton J.
 960 S. Spring, Apt. D
 Miller, Mrs. R. J. 1563 S. Spring
 Mills, Mrs. Fred. 513 Oakley
 Mino, Mrs. Victor. Newburgh Rd.
 Moehlenkamp, Mrs. Charles
 305 E. Iowa
 Neidermayer, Mrs. A. J.
 280 Bayard Pk. Dr.
 Newman, Mrs. A. E. Harrelton Ct.
 Pollard, Mrs. W. S. 1230 S.E. 2nd
 Present, Mrs. Julian. 201 Parker
 Pugh, Mrs. Willis L. 559 Ruston
 Ratcliffe, Mrs. A. W. 510 S.E. 1st
 Ravdin, Mrs. Bernard. 706 Sunset
 Ravdin, Mrs. Marcus
 1666 Bayard Pk. Dr.
 Reich, Mrs. Clarence
 1209 N. Fulton

Richey, Mrs. C. O. 400 S. Kelsay
 Rininger, Mrs. H. C. 1920 Wash.
 Ritz, Mrs. A. S. 1375 E. Chandler
 Rosenblatt, Mrs. Bernard
 759 S. Alvord
 Ruddick, Mrs. H. C.
 845 Ravenswood
 Rusche, Mrs. H. J. 514 Harriet
 Scales, Mrs. A. B. 429 S. Alvord
 Schirmer, Mrs. R. H.
 2710 Hartmetz
 Schirmer, Mrs. William
 2005 W. Franklin
 Schneider, Mrs. Charles P.
 2924 W. Maryland
 Schriefer, Mrs. V. V. 390 S. Alvord
 Slaughter, Mrs. Howard
 800 St. James
 Slaughter, Mrs. W. Russell
 960 S. Rotherwood
 Springstun, Mrs. W. Russell
 2516 Adams
 Stork, Mrs. Urban. 414 S. Kelsay
 Sutter, Mrs. C. C. 3008 Broadway
 Tweedall, Mrs. D. G.
 2202 W. Illinois
 Underwood, Mrs. G. B. 1408 Lincoln
 Visher, Mrs. J. W. 1066 Madison
 Weiss, Mrs. H. G. 1014 E. Powell
 Welborn, Mrs. Mell B. Mt. Auburn
 Wesson, Mrs. Thos. 814 Lombard
 Wilhelmus, Mrs. Gilbert M.
 1650 E. Walnut
 Willison, Mrs. George
 411 Lincoln Pk. Dr.
 Wilson, Mrs. O. K. 804 Wash.
 Wilson, Mrs. Ralph. 804 Wash.
 Wishart, Mrs. Shelby. 1105 S.E. 1st
 Wood, Mrs. Wm. H. 3306 E. Powell
 Wyatt, Mrs. Fred
 403 Cambridge Arms
 Wynn, Mrs. J. F. 651 S. Weinbach
 Yunker, Mrs. Philip. 2418 Lincoln
 Oliphant, Mrs. Frank. Mt. Vernon
 Durkee, Mrs. Melvin. Newburg
 Wilhelmus, Mrs. C. K. Newburg
 Zwickel, Mrs. R. E. Newburg
 Kime, Mrs. J. T. Petersburg
 Baker, Mrs. Clarence. Rockport
 Glackman, Mrs. J. C., Jr. Rockport
 Purcell, Mrs. Jack. Winslow

VIGO COUNTY

McIntosh, Mrs. Wilbert. Riley
 Silverman, Mrs. C. S. Seelyville

Terre Haute

Agee, Mrs. E. B. 1014 S. 22nd
 Allen, Mrs. O. T. 32 S. 20th
 Anderson, Mrs. W. C. 380 S. 22nd
 Asbury, Mrs. W. D. R. R. 3
 Ault, Mrs. Roy S. 1674A N. 7th
 Baldrige, Mrs. E. R. 1435 S. 6th
 Baldrige, Mrs. W. O. 2500 N. 9th
 Blum, Mrs. Leon. 1101 S. 6th
 Bohannon, Mrs. M. J. 1400 N. 7th
 Bopp, Mrs. H. W. 132 Barton
 Bopp, Mrs. James. 2635 Wilson
 Bradley, Mrs. S. C. 916 S. 25th
 Brown, Mrs. Robert. 16 Monterey
 Caffee, Mrs. Amos. 518 Chestnut
 Ca Jacob, Mrs. Melville. 1000 S. 6th
 Carpenter, Mrs. G. C. 122 Barton
 Combs, Mrs. C. N. 2516 N. 9th
 Conklin, Mrs. J. O. 1006 S. 7th

VIGO COUNTY

(Terre Haute—Continued)

Connelly, Mrs. J. J. . . . 213 Barton
Curry, Mrs. C. A. . . . 1402 S. 17th
Decker, Mrs. Harvey. . . . R. R. 3
Donnelly, Mrs. J. E. . . . 2230 Garfield
Duenweg, Mrs. R. . . . 820 S. Center
Dyer, Mrs. G. W. . . . 2710 Wilson
Edmondson, Mrs. R. E. . . . 2201 S. Center

Forsyth, Mrs. D. H. . . . 714 S. 8th
Freed, Mrs. J. E. . . . 2408 N. 10th
Fuqua, Mrs. H. B. . . . 2303 N. 9th
Gilbert, Mrs. Ivan. . . . 2641 Crawford
Gillum, Mrs. J. R. . . . 805 S. Center
Goodman, Mrs. H. T. . . . 328 Potomac
Haslem, Mrs. E. R. . . . 205 Potomac
Haslem, Mrs. J. R. . . . 2144 Poplar
Humphrey, Mrs. P. E. . . . 815 Maple
Johnson, Mrs. P. D. . . . 1562 4th Ave.
Kriebel, Mrs. W. W. . . . 2100 S. Center
Kunkler, Mrs. W. C. . . . 1119 S. Center
LaBier, Mrs. C. R. . . . 414 S. 22nd
LaBier, Mrs. Russell. . . . 21 McKinley
Lancet, Mrs. R. O. . . . 426 S. 25th
Loewenstein, Mrs. W. L. . . . 1421 S. 7th
Luckett, Mrs. C. L. . . . 1232 S. Center
Mahoney, Mrs. C. S. . . . 1438 S. Center
Malone, Mrs. L. A. . . . 342 S. 22nd
Mattox, Mrs. Don M. . . . 722 S. 5th
Mattox, Mrs. E. L. . . . Deming Wds.
McCarthy, Mrs. F. G. . . . 926 S. 6th
McCormick, Mrs. W. C. . . . 2156 College

McEwen, Mrs. J. W. . . . R. R. 5
McLaughlin, Mrs. G. C. . . . Box 413, R. R. 4

Meyn, Mrs. W. D. . . . 2101 S. 9th
Miller, Mrs. D. B. . . . 903 S. 7th
Mitchell, Mrs. A. H. . . . 333 S. 22nd
Nay, Mrs. E. O. . . . 29 S. 20th
Oliphant, Mrs. R. W. . . . 123 Jackson
Pearce, Mrs. Roy V. . . . 523 N. 7th
Pierce, Mrs. H. J. . . . 1514 S. Center
Rarick, Mrs. A. J. . . . 527 S. 5th
Reynolds, Mrs. R. J. . . . 2138 Deming
Riggs, Mrs. Floyd. . . . 137 S. 24th
Richart, Mrs. J. V. . . . Deming Wds.
Sayers, Mrs. F. E. . . . R. R. 5, Robinwood

Scherb, Mrs. B. E. . . . 422 S. 25th
Schott, Mrs. E. J. . . . 901 Barton
Shaffer, Mrs. J. S. . . . 2200 3rd Ave.
Shaffer, Mrs. Mignon. . . . 2200 3rd Ave.
Schumaker, Mrs. R. A. . . . 731 S. Center

Showalter, Mrs. J. R. . . . 2638 N. 8th
Siebenmorgen, Mrs. L. . . . 1200 S. 8th
Siebenmorgen, Mrs. Paul . . . 1130 S. 8th

Silverman, Mrs. N. M. . . . 1220 S. 8th
Speas, Mrs. R. G. . . . 2800 S. 7th
Spigler, Mrs. Jas. . . . 1436 S. 6th
Stoelting, Mrs. J. L. . . . 1919 N. 7th
Strong, Mrs. D. S. . . . 25th & Lafayette

Sullivan, Mrs. J. M. . . . 2242 College
Topping, Mrs. M. C. . . . 152 Monterey
Van Arsdall, Mrs. C. R. . . . 2229 Crawford

Van Cleave, Mrs. M. B. . . . 505 S. 4th
Vandivier, Mrs. H. R. . . . 225 Madison
Voges, Mrs. Ed C. . . . 137 S. 20th
Warren, Mrs. Ward. . . . 1900 N. 9th
Weber, Mrs. Joseph. . . . 2121 N. 11th
White, Mrs. J. V. . . . 100 S. 20th

Wiedemann, Mrs. F. E. . . . 1530 S. 6th
Yung, Mrs. J. R. . . . 1115 S. 6th
Zaring, Mrs. E. T. . . . 3325 Wabash, Apt. 3

Zwerner, Mrs. Paul. . . . 712 Collett
Utterback, Mrs. A. W. . . . Terre Haute

WAYNE-UNION COUNTY

Richmond

Ake, Mrs. Loren. . . . 1707 E. Main
Allen, Mrs. H. E. . . . 163 S. Easthaven
Ballenger, Mrs. W. E. . . . 301 S. 22nd
Buche, Mrs. F. P. . . . 106 S. 7th
Campbell, Mrs. Perry. . . . Cart Rd.
Coble, Mrs. Frank. . . . Liberty Pike
Cook, Mrs. Norman. . . . 305 N. 20th
Cox, Mrs. Leon. . . . 148 S. 21st
Ewbanks, J. Nelson . . . Smith-Esteb Hosp.

Hadley, Mrs. Harvey . . . 308 First Nat. Bk.
Hayes, Mrs. G. R. . . . Keystone Apts.

Hill, Mrs. H. D. . . . 600 S. 14th
Hoffman, Mrs. Curtiss. . . . 204 S. 21st
Holland, Mrs. E. E. . . . 1907 E. Main
Hagie, Mrs. Frank. . . . 164 S. 20th
Hufnagel, Mrs. C. J. . . . 436 S. 12th
Hunt, Mrs. Gayle. . . . 2109 S. E St.
Hunt, Mrs. George. . . . 201 N. 7th
Johnson, Mrs. M. S. . . . 103 N. 10th
Johnson, Mrs. P. S. . . . 200 S. 18th
Kime, Mrs. Charles. . . . 1623 Chester
Krueger, Mrs. F. W. . . . Henley Rd., S.
Laird, Mrs. L. A. . . . Richmond State Hosp.

Lee, Mrs. G. W. . . . 404 S. 15th
Logan, Mrs. Jas. Z. . . . 36 S. 15th
Mader, Mrs. John. . . . 227 S.W. 2nd
Meredith, Mrs. Elwood. . . . 200 S. 20th
Pentecost, Mrs. Paul . . . 1021 Abington Pike

Ross, Mrs. James. . . . 227½ S. 11th
Ross, Mrs. H. P. . . . 220 S. 19th
Sage, Mrs. Chas. F. . . . 48 S. 11th
Sage, Mrs. Charles V. . . . 1015 Abington Pike

Shields, Mrs. Tom S. . . . 47½ S. 11th
Snyder, Mrs. Morris. . . . 521 S.W. A St.
Stamper, Mrs. L. A. . . . 420 S. 22nd
Stepleton, Mrs. Jno. . . . 1120 Central
Sweet, Mrs. Howard. . . . 20 S. 22nd
Vance, Mrs. Wm. . . . 200 S. 21st
Wanninger, Mrs. Horace . . . 315 S. 15th

Warrick, Mrs. F. B. . . . 22 DeBolt
Weinstein, Mrs. E. B. . . . 1900 S. E St.
Wertenberger, Mrs. Morris . . . 115 S. 16th

Whallon, Mrs. Arthur. . . . 29 S. 10th
Wisener, Mrs. Guthrie. . . . 401 S. 18th
Hill, Mrs. Paul. . . . Cambridge City
Kenyon, Mrs. Emil. . . . Cambridge City
Barton, Mrs. W. M. . . . Centerville
Lewis, Mrs. Frank. . . . Liberty

WELLS COUNTY

Bluffton

Annis, Mrs. H. B. . . . 225 W. Central
Aucreman, Mrs. C. J. . . . 513 W. South
Carter, Mrs. F. S. . . . 117 W. Wabash
Caylor, Mrs. C. E. . . . 114 S. Williams
Caylor, Mrs. H. D. . . . 411 W. Market
Caylor, Mrs. T. E. . . . 114 S. Williams
Collett, Mrs. H. S. . . . R. R. 3, Box 232

Cook, Mrs. R. G. . . . R. R. 3, Box 44
Dorrance, Mrs. Thomas O. . . . 218 W. Central

Eisaman, Mrs. J. L. . . . 427 W. Wiley
Johnston, Mrs. Robert . . . 811 S. Morgan

King, Mrs. E. A. . . . 320 S. Main
Nickel, Mrs. Allen. . . . 504 W. Cherry
Ramsey, Mrs. R. A. . . . 212 Central
Smith, Mrs. H. B. . . . 333 S. Wayne
Tirman, Mrs. Wallace . . . 524 W. Wabash

Yoder, Mrs. R. P. . . . S. Wayne

WHITLEY COUNTY

Haller, Mrs. R. W. . . . Churubusco
Columbia City

Heritier, Mrs. C. Jules . . . 410 E. Van Buren

Langohr, Mrs. John. . . . N. Main
Lehmberg, Mrs. O. F. E. . . . Van Buren
Nolt, Mrs. E. V. . . . S. Chauncey
Pence, Mrs. Ben F. . . . W. Jackson
Thompson, Mrs. Frank . . . E. Van Buren

Garber, Mrs. P. A. . . . South Whitley
Huffman, Mrs. Park. . . . South Whitley

MEMBERS AT LARGE

Adair, Mrs. Wm. K. . . . 208 Armstrong, Crothersville
Anderson, Mrs. Richard. . . . Vincennes
Ashworth, Mrs. L. N. . . . Connersville
Badders, Mrs. A. C. . . . Portland
Baker, Mrs. R. E. . . . Orleans
Bear, Mrs. Lowery H. (Hon.) . . . Vevay

Benz, Mrs. Jesse. . . . Box 115, Marengo
Bloomer, Mrs. J. R. . . . Rockville
Bloomer, Mrs. Richd. S. . . . Rockville
Boren, Mrs. Paul L. . . . Poseyville
Bounell, Mrs. E. C. . . . Hillsboro
Brubaker, Mrs. O. G. . . . 402 N. Main, No. Manchester

Carneal, Mrs. T. E. . . . Winamac
Colglazier, Mrs. G. G. . . . Leipsic
Cummings, Mrs. D. J. . . . Brownstown
Davis, Mrs. J. A. . . . Flat Rock
Dillman, Mrs. Carl E. . . . Corydon
Dreyer, Mrs. R. W. . . . Knightstown
Farabee, Mrs. C. R. . . . North Judson
Gable, Mrs. H. B. . . . Monticello
Gillespie, Mrs. G. R. . . . Brownstown
Harstad, Mrs. Casper. . . . Rockville
Hisrich, Mrs. L. W. . . . 1 Henry St., Batesville

Humphrey, Mrs. J. E. . . . 1223 E. St. Clair, Vincennes

Hursey, Virgil G. . . . Milford
Huckleberry, Mrs. Irvin E. . . . Salem
Johnson, Mrs. W. A. . . . Perryville
Leininger, Mrs. H. A. P. . . . 1226 E. Market, Warsaw

Lett, Mrs. E. J. . . . Loogootee
Life, Mrs. Homer. . . . New Castle
Linton, Mrs. C. E. . . . Medaryville
McClain, Mrs. M. L. . . . Scottsburg
McMahon, Mrs. Virgil . . . R. R. 1, Vincennes

McCaskey, Mrs. G. A. . . . Winamac
Mahuron, Mrs. B. L. . . . Greensburg
Manley, Mrs. C. H. . . . Rising Sun
May, Mrs. George A. . . . R. R. 5, Madison

Maurer, Mrs. J. F. . . . Brazil

County Presidents

- ADAMS—Mrs. Myron Habegger, 505 Clark St., Berne.
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- RUSH—Mrs. R. B. Johnson, 841 N. Harrison, Rushville.
- ST. JOSEPH—Mrs. Marion W. Hillman, 1516 Marquette Blvd., South Bend.
- SULLIVAN—Mrs. L. G. Zerfas, Merom.
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- VANDEBURGH—Mrs. L. Edward Gaul, 508 S. Beebe St., Evansville.
- VIGO—Mrs. H. W. Bopp, 132 Barton Ave., Terre Haute.
- WAYNE-UNION—Mrs. Norman R. Cook, 305 N. 20th St., Richmond.
- WHITLEY—Mrs. C. J. Heritier, 410 E. Van Buren St., Columbia City.
- WELLS—Mrs. H. Brooks Smith, Bluffton.
- PORTER—Mrs. Ralph C. Eades, 501 East Lincolnway, Valparaiso.



President's Page



WHO SAID THAT?

"The White House is undergoing repairs and remodeling. The need for action was dramatized recently when one leg of Margaret Truman's piano poked through the first floor ceiling, but there are still those who shudder at the thought of changing anything about the venerable and revered old mansion. Most will probably agree, however, that the job must be done. Repairs now mean that the building will stand strong and firm for many years to come."

"The medical profession has beams that need strengthening, too. They've been dramatized by recurrent attacks on the doctors. A few of the danger spots are excessive fees, maldistribution of doctors, night and emergency calls that go unheeded, rebates, insufficient postgraduate education in certain areas, poor press relations, lack of cooperation with laymen and related health groups in planning for medical care, neglecting to publicize and implement our 12-point health program, and omitting to tell the people about the many progressive activities of the profession on their behalf."

* * *

"We need to put our house in order. Despite its outward coat of white paint, even the White House wasn't able to conceal internal weaknesses!"

NO, I DID NOT SAY THAT

Although there is something strangely familiar in the above paragraphs, it is not a repetition of the "old stuff" of "yours truly," but it is a direct quotation from a recent issue of "The PR Doctor," issued by the Public Relations Department of the American Medical Association. I have no intention of opening up an old sore, but I have been told "If you expect your page to be read, it must not be too dull and must carry something of human interest." I am sure we are all interested in what happened to Margaret Truman's piano leg. Now that you are down here, please read on, for

I DO WISH TO SAY:

In the first six months of the centennial year the Indiana State Medical Association and its component county societies have a commendable record of achievements. The tremendous output of our headquarters office, made possible by new equipment and additional personnel, the new look of our state JOURNAL, the state-wide circulation of the "ISMA News Flashes," the fine job that is being done by our A.M.A. Campaign Coordinating Committee, and the phenomenal growth of our Mutual Medical Insurance, Inc., are just a few of the highlights of organized medicine in Indiana. The agendas of the meetings of the Council and Executive Committee have required many long hours for discussion and action on many important subjects.

Most of our state committees have held one or more meetings, and it is expected that every committee will meet before August first and present a constructive report to the House of Delegates to be included in the archives of our centennial. These committees are the workshops of our association at the state level. They are contributing much to the advancement of scientific medical care in Indiana and this year are aiding in the correlation of all the meritorious agencies of health under the banner of American Medicine.

Back home, at the crossroads in the towns and villages, and in the metropolitan centers as well, the doctors of our county medical societies are doing a job that is the real answer to the threat of Socialized Medicine.

Our county societies, almost without exception, are alert to their responsibility in the community. They are spreading the doctrine of the A.M.A. Educational Campaign and many counties have appointed special committees to do this important work.

There is a spirit of cooperation and improved civic relationship in the medical profession throughout the state, and in many counties the local Health Councils and the related health groups are receiving scientific guidance and active participation from the county medical societies. More and more counties are sponsoring community enrollment campaigns in Blue Shield and Blue Cross.

"Around the clock" medical care plans are almost an epidemic among our county societies and are now established and working well in a majority of the counties in Indiana. Many of our county societies are carrying their cause directly to the people through the local press and radio.

These are just a few of the things our county societies are doing, each in its own way and with courageous initiative, endeavoring to solve the local problems of medical care.

These are the things that are creating better press relationship, better civic relationship, and better medical care for the people of our state.

Medical service will no longer be a political issue in Indiana, when all are doing what many of our county medical societies are doing now.

Augustus D. Haus

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION*

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803.)

CHAPTER I

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

* Sir Thomas Watson.

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATIONAL INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal

to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SECTION 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is

* Adopted by the American Medical Association House of Delegates on June 6, 1949.

* Nicon, father of Galen.

a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION UPHOLDING THE HONOR OF THE PROFESSION

SECTION 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SECTION 1.—As a general rule, a physician should not attempt to treat members of his family or himself.

Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best

to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION LIMITS OF GRATUITOUS SERVICE

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC
PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION FOR THE ADVANCEMENT OF MEDICINE AND PUBLIC HEALTH*

THE American Medical Association in February, 1949, issued a revised 12 Point Program for the Advancement of Medicine and Public Health. This program was a statement of principles only. Considerable study has been given to this program. The Board of Trustees feels that these 12 points cover all the essential principles necessary for a satisfactory program. It believes, however, that these 12 points need further elaboration as to detail so that the implementation of them may be more clearly understood. Hence, the board submits to the House of Delegates, for its consideration, the following statement consisting of an elaboration of the 12 points, together with a brief statement of the board's stand on certain legislative proposals.

A FEDERAL DEPARTMENT OF HEALTH

1. *Creation of a Federal Department of Health of Cabinet Status with a Secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this Department, except for the military activities of the medical services of the armed forces.*

Since 1884, the American Medical Association has demanded a Federal Department of Health with a Secretary, who is a physician, in charge.

At the present time the various agencies concerned with health are distributed in various government departments. It would be in the interest of efficiency and economy to have them under one

head to avoid duplication of effort and diversion of activity.

Various suggestions have been made to establish a Department of Welfare, a Department of Education, Health and Welfare, and an independent Health Agency. The health of the people is certainly important enough to warrant an independent agency, in accordance with the recommendations of the Hoover Commission. The argument has been made that it is not the policy of our government to have an expert in charge of a department, but that the experts should be subservient to the chief of the department. In answer to this, the American Medical Association feels that no other government department is so closely concerned with the individual as would be a Department of Health. Other departments deal as a rule with the population as a group. Matters of health are often individual and no one could be better qualified to superintend matters of individual health than a physician. At this time we urge support of the report of the Hoover Commission on this subject, which recommends an independent Health Agency under which will be assembled all activities concerned with health except those of the Armed Forces and Veterans Administration.

MEDICAL RESEARCH

2. *Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.*

The Steelman Report states that \$110,000,000 is now spent for medical research, \$55,000,000 of this comes from industry and the balance from the government and from private foundations. These funds are not adequate and further funds for re-

* This elaboration on the purposes and intent of the A.M.A. 12 point program was issued by the A.M.A. Board of Trustees at Atlantic City in June.

search are difficult to obtain. Bills are now in Congress to establish a National Science Foundation, to facilitate coordination of research and make available funds for research in medical and other sciences. The American Medical Association recognizes that research is the basis of medical progress. We urge the establishment of a National Science Foundation with appropriate federal support.

VOLUNTARY INSURANCE

3. *Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.*

The voluntary hospital and medical care insurance development in the United States has been the most rapidly growing insurance project in the history of the country. The movement started slowly. At the end of the first seven years of voluntary hospital insurance under the Blue Cross, only 2,870,000 subscribers were enrolled. Now after about 16 years there are 32,500,000 enrolled in the Blue Cross and over 20,000,000 enrolled in industrial and commercial types of plans, and all three types are continuing their rapid growth. Medical care insurance developed about five years after the Blue Cross hospital insurance began. After the first seven years, there were only 2,845,000 enrolled in nonprofit plans. Now six years later there are over 11,000,000 enrolled in these plans and 26,000,000 others enrolled in commercial and industrial plans. These plans likewise are growing at a rapid rate. Besides these plans there are cooperative and special health plans of labor. For the protection of the public the American Medical Association has aided in the development of standards for voluntary insurance plans. The association is conducting a campaign to educate both the public and the profession on the value of voluntary medical care plans, recognizing that serious illness is a financial handicap to millions of Americans. It is making every effort to assist in extending the coverage and distribution of these plans, particularly in those rural areas now lacking them. The association has recognized the desirability of a National Voluntary Enrollment Agency for the nonprofit plans to facilitate interchange and enrollment of companies with national payrolls. It is believed that at least 80,000,000 will be enrolled within a reasonable time in voluntary hospital and medical care plans. When we add this number to the 24,000,000 now receiving their medical care in whole or in part from the government, the industrial workers covered by established health plans and the approximately 5,000,000 indigent, it will be seen that a greater portion of the

population will be provided for than by any other means suggested.

MEDICAL CARE AUTHORITY WITH CONSUMER REPRESENTATION

4. *Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.*

It would be advisable to have in each state an authority to receive, administer and distribute funds from government sources to prevent duplication of effort and to insure that all needs will be met. Such an authority should have representation of all groups concerned, including both the distributors and consumers of medical care.

NEW FACILITIES

5. *Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.*

The American Medical Association supported the passage of the National Hospital Survey and Construction Act (Hill-Burton Bill). Bills are now in Congress to extend the life of this act and to double the funds available. The American Medical Association supports such legislation with proper controls to insure local origination of demands and demonstration of need. Extension of hospital and diagnostic facilities in areas now lacking them will help solve the problem of a better distribution of physicians.

PUBLIC HEALTH

6. *Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.*

The American Medical Association regards this item in its program as highly important. Large areas of the country are without proper public health service and many of these areas cannot afford such service. Prevention of disease at the source will decrease the need for medical care. There are bills now in Congress to extend Federal aid to communities needing it for this purpose. We support legislation which will permit aid to local communities where suitable organizations have been developed for the administration as suggested in Item No. 4 (Medical Care Authority) and where public health agencies are limited to the field of public health. There is a shortage of qualified public health officials and the Public Health Schools are graduating too few students. The reasons for

this are largely monetary and political. Public Health officials are often not paid in accordance with the scale of pay of other government officials with like or even less responsibility. Often public health officials are subject to political control, making their tenure of office uncertain and efficient service impossible.

MENTAL HYGIENE

7. *The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.*

Mental hygiene is becoming increasingly important. This field is being invaded by charlatans and the public is being done a disservice. More adequate state controls are needed to protect the public against unqualified practitioners. State medical societies should sponsor the development of suitable mental hygiene clinics where they are needed. The American Medical Association stands ready to assist state societies and other recognized scientific bodies in developing a suitable program of mental hygiene. Although bills have been introduced into Congress on this subject, far more consideration and study must be given before any program is enacted.

HEALTH EDUCATION

8. *Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.*

The success of any medical care program in the United States depends on public cooperation and keeping the people informed. Through its Bureau of Health Education the American Medical Association sponsors radio broadcasts, prepares pamphlets for distribution, exhibits on health, and arranges for lectures. This is insufficient and each state and county society is urged to develop a Bureau of Health Education for the public, so that the latter may not only be kept informed of facilities available, but of progress in medicine.

CHRONIC DISEASES AND THE AGED

9. *Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.*

The care of the aged and the chronic invalid will henceforth be an increasing problem. This is because the increased span of life brought about by the decrease in infant mortality and decrease in mortality from infectious disease has resulted in more people living to the age at which they are subject to the degenerative diseases of middle and old age. Since 1900 the population of the country has doubled, but the number of people over 64 has quadrupled. Paradoxical as it may sound, the reason we have an increasing number of chronic invalids is because these people have received good medical care in youth. The American people need greater provision for the care of chronic illness,

but the buildings required need not be on as expensive a scale as those necessary for the care of acute illness. The American Medical Association, the American Public Health Association, the American Hospital Association, and the American Public Welfare Association have jointly created a Commission on Chronic Illness which hopes to stimulate the establishment of a program in each state so that the status of the chronically ill may be improved and the continued loss to society because of chronic illness may be prevented.

VETERANS' MEDICAL CARE

10. *Maintenance of existing high standards of medical care for veterans, including extension of facilities where need can be shown where practical. Care of the veteran should be in his own community by a physician of his own choice.*

The American Medical Association desires that every citizen receive the highest quality of medical care and recognizes the special consideration owed to the veteran. The American Medical Association is concerned that the veteran receive the highest quality of medical care and believes that he can usually be taken care of to his satisfaction in his own community by a physician of his choice.

INDUSTRIAL MEDICINE

11. *Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highways, home and on the farm.*

The American Medical Association approves the expansion of service in the field of industrial medicine. It invites attention to the fact that accidents are fourth in the list of the causes of death and that automobile accidents are fourth in the list of accidental deaths. It is ready to cooperate with the National Safety Council and other organizations to find means of reducing deaths from accidents.

The Council on Industrial Health of the A.M.A. has set up a permanent conference group with labor and management, to discuss ways and means of extending industrial medicine, accident prevention and health education of workers; to clarify the status of physicians and medical organizations in relation to the entire range of industrial health activity; and to provide a method for the consideration of other aspects of medical service having industrial application.

Professional relations have been established with all the various professional groups involved in accident prevention.

Expanded service has been developed with workmen's compensation, unemployment compensation and rehabilitation.

Industrial medical care plans are increasing; as good medical standards and resources in industry improve they can be of great service in maintaining independence and self-determination, and in counteracting tendencies toward centralization and control.

MEDICAL EDUCATION AND PERSONNEL

12. *Adequate support with funds free from political control and regulation of the medical and allied professional schools.*

Some medical schools are finding it difficult to secure sufficient funds to maintain their standards of training. The American Medical Association would prefer to see medical schools receive the support they require from private philanthropy or local public funds. Unless and until such support is provided, it may be necessary for some medical schools to accept financial aid from the federal government. Such aid, however, must carry with it the assurance of freedom from political control and regulation.

To preserve the freedom and independence of the medical schools it is important that the responsibility for determining which schools may qualify for federal aid should reside in the states. This can be satisfactorily accomplished if the legislation provides that any medical school shall be eligible for financial aid if three-fourths of the states, through their medical licensing authorities, judge the school to be conducting an educational program of sufficiently high quality to warrant the admission of its graduates to their state examinations for medical licensure.

To encourage continued local support of medical education from public and private funds, the formula for allocating federal aid should provide only a limited portion of a school's total budget.

Since medical schools are already increasing enrollments as rapidly as they can expand their facilities, the provision of a relatively large financial premium which might induce certain schools to enroll more students than they could properly accommodate should be avoided.

The formulae for the allocation of all funds should be simple in principle and written into the law. The responsibility and authority of the officials administering the program should be limited to an audit to determine that the funds are employed for the general purposes for which they were granted.

Any federal scholarship program should leave the medical schools entirely free in the selection of their students and should avoid the regimentation of the future careers of the recipients.

It is not the function of the Federal government to build and operate medical schools.

* * *

The American Medical Association is firmly opposed to the medical care section of S-1679 and certain other sections of the bill, the reasons for opposition to which are cited above, and to any other bill which lodges primary initiative and control of medical care in a federal bureaucracy; that contains uniform and compulsory features to be established nationally and imposes a direct federal tax on every worker to finance the program. Such plans concentrate further power in the central government. They absorb functions which are much better retained at the local level and they

greatly increase the overall cost of providing health services. Most important, existing evidence establishes the fact that such plans lead to a widespread and serious deterioration of the quality of medical care.

Government is unable to deliver the services that are promised and which would be paid by the plan set forth in S-1679; the proposal constitutes an extreme example of compulsory paternalism, impossible of practical operation, and contrary to the principles of American democracy.

The Council on Medical Service of the American Medical Association is holding conferences with cooperatives and various other farm and labor groups. As a result of these conferences progress is definitely being made.

The American Medical Association, through its Board of Trustees, has taken steps toward a conference of representatives of interested groups to consider this program and such elaboration as may seem indicated in the public interest.

To summarize, the American Medical Association supports:

- (1) The establishment of an independent national health agency with a physician in charge.
- (2) The establishment of a national Science Foundation.
- (3) Rapid extension of voluntary hospital and medical care insurance.
- (4) The establishment of a medical care authority in each state to administer and distribute government funds with adequate representation of interested groups.
- (5) Extension of hospital and diagnostic facilities under suitable control.
- (6) Provision for establishment of complete public health coverage for the country, with federal aid where the need can be shown, with proper remuneration of public health officers and insuring them freedom from political control.
- (7) Increased safeguards for the public against charlatans in the field of mental hygiene and establishment of necessary mental hygiene clinics.
- (8) Continued and expanded public health education by the A.M.A., state and county societies.
- (9) Furtherance of the care of the chronically ill, through support of the Commission on Chronic Illness.
- (10) Protection of the veteran in his rights to medical care of the highest quality.
- (11) Continuation of the activities of the Council on Industrial Health, and cooperation with the National Safety Council and other organizations in an effort to reduce accidents.
- (12) Encouragement of local and private support of medical education and use of government aid only if shown absolutely essential, and then under suitable controls to protect the independence of medical education.

Finally, opposition to any plan of government controlled medical care compulsory in nature and supported by payroll taxation, with inevitable deterioration of the quality of medical care.

1949 INSTRUCTIONAL COURSES
FOR THE MEMBER IN GENERAL PRACTICE

In the next issue of *THE JOURNAL* the schedule of 30 Instructional Courses will be carried. These courses will be given on Monday, September 26, 1949.

The courses will be given at 11:00 a.m., 1:00 p.m., 2:00 p.m., 3:00 p.m. and 4:00 p.m. You will be able to select a curriculum of five classes.

Almost every phase of medicine will be covered, with special attention to diagnostic signs and symptoms, and to available therapy.

Each class will be limited to an attendance of 30 members, in order to enhance teaching opportunity and to permit open discussion of the subject.

All classes will be held on one floor of the Murat Temple.

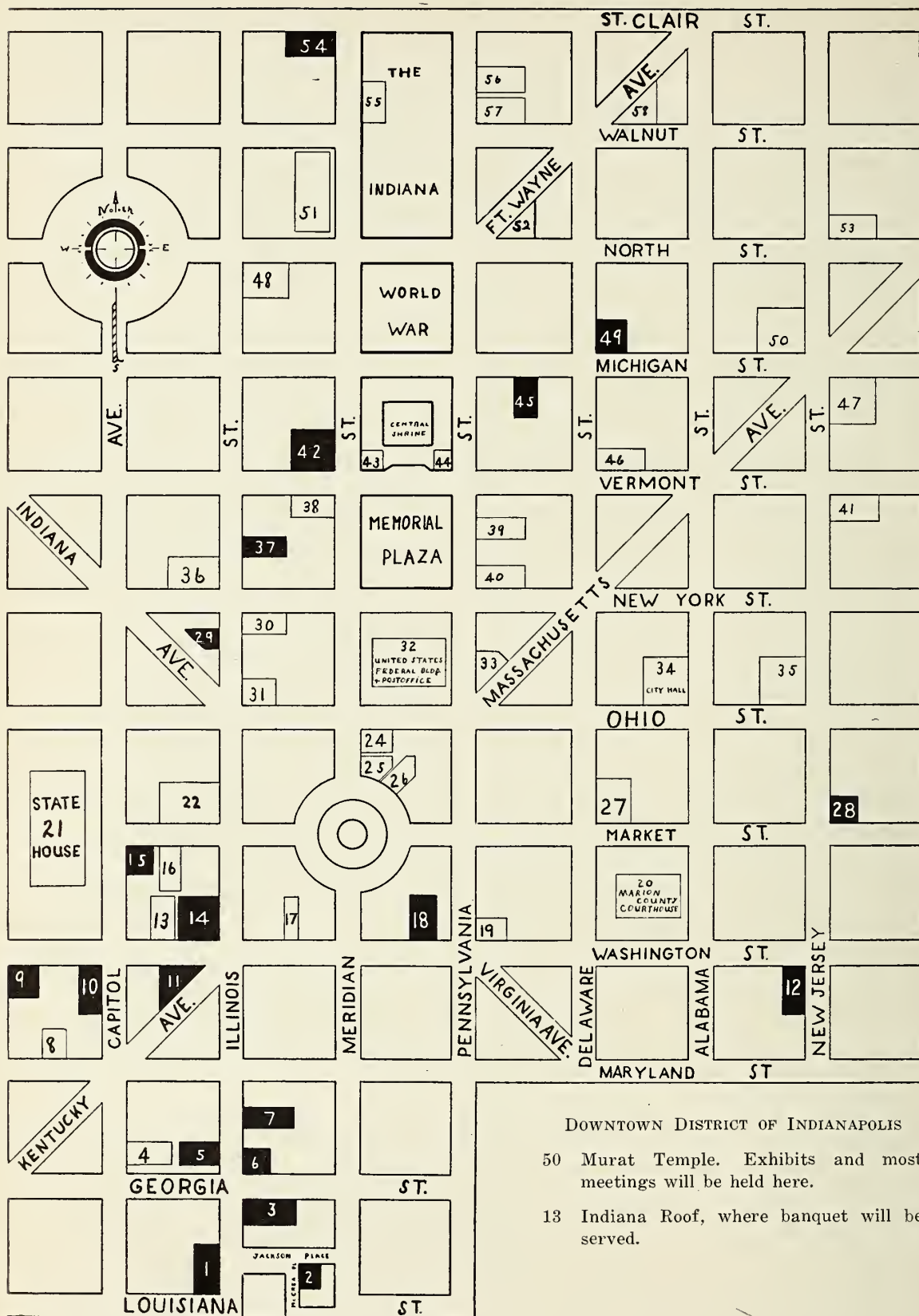
Admission will be by reserved tickets. An order blank for tickets will appear below the schedule in the next issue of *THE JOURNAL*.

Reservations will be made in the order of their receipt. Experience indicates that early reservations are necessary to insure proper admission to the courses you want to attend. Most of the classes are closed prior to general registration.

This year the session opens on MONDAY, September 26. Plan to come early enough to start with Instructional Courses.

Watch for the schedule! Order Promptly!

The Committee:	GORDON W. BATMAN	} Co-Chairmen
	RUSSELL A. SAGE	
	J. LAWRENCE SIMS	
	HERBERT L. EGBERT	
	A. G. FUNKHOUSER	
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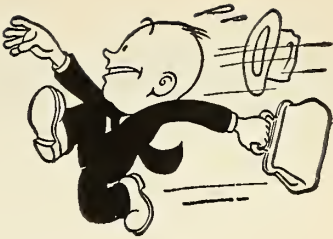


Headin' For Indianapolis!

September 26-27-28 and 29, 1949

Centennial Session

Indiana State Medical Association



--- TIME TO MAKE YOUR HOTEL RESERVATION ---

Hotels	Rates
(Numbers Indicate Locations. See Map on Opposite Page)	
54 Antlers	\$3.75- \$8.50
2 Barnes	\$2.00- \$6.00
49 Barton	\$2.25- \$7.00
14 Claypool	\$4.00-\$10.00
* Graylynn	\$4.00- \$6.00
15 Harrison	\$3.25- \$8.75
11 Lincoln	\$3.50-\$10.00
37 Linden	\$2.00- \$6.00
* Marott	\$4.50-\$10.00
* Pennsylvania	\$2.75- \$5.00
* Riley	\$2.25- \$6.00
3 Severin	\$3.50-\$10.00
* Sheffield	\$3.50- \$7.00
1 Spencer	\$2.50- \$6.00
42 Spink-Arms	\$3.00-\$12.00
17 Stratford	\$2.00- \$6.00
7 Warren	\$3.50- \$8.50
18 Washington	\$3.25- \$8.50

FOUR BIG DAYS AND NIGHTS

Monday, September 26—Stag party for men. Party for women.

Tuesday, September 27—Musical program. National speaker.

Wednesday, September 28—National speaker on semi-scientific subject.

Thursday, September 29—Annual dinner, followed by dancing to name band.

Scientific Lectures and Television Every Day

Hotels	Rates
9 Williams	\$2.25- \$6.00
29 York	\$2.00- \$5.00

* Not shown on map.

Committee on Housing:
JACOB E. GILLESPIE, M.D., Chairman
523 Hume Mansur Building
Indianapolis 4

HOTEL RESERVATION BLANK

Clip and Mail this coupon to hotel

ManagerHotel, Indianapolis, Indiana

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, September 26, 27, 28 and 29, or for such other period as may be indicated herein.

☐ Single Room with bath

☐ Double Room with bath

Price:.....

☐ Twin Bed Room with bath

☐ Suite

Arrival dateA. M.P. M.

Departure dateA. M.P. M.

PLEASE VERIFY MY RESERVATION

Name.....

Address.....

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Medical Panorama *by the* ASSOCIATE EDITOR

MORE WISDOM FROM THE SOUTH

In April we printed some cogent remarks quoted from Louisiana. Since then an editorial in *The Journal of the Florida Medical Association* for March, 1949, has come to our attention. It deals with a most important phase of medicine's fight with bureaucracy and should be read carefully by all medicos who make any attempt to uphold our side of the question—and we hope all of our readers do take such action. This article tells you how to keep your powder dry and how to keep the other fellow from spiking your guns:

"THE PHYSICIANS APPROACH TO THE PUBLIC

"There seems to be a current theory, promoted no doubt by a very few, that those who know most about anything are prejudiced and hence are not reliable witnesses.

"Physicians who know most about maintaining the public health and have spent a great portion of their lives studying health programs were not consulted by Mr. Ewing, Federal Security Administrator, who was appointed by President Truman to make a report on the nation's health.

"Little wonder that many physicians feel very strongly on this subject. Little wonder that they, when called upon to speak in public, are apt to express themselves with much vigor and feeling. Little wonder that they sometimes give the impression that they harbor animosity and bear ill feeling toward those who disagree.

"Care should be taken to guard against that manner, however, for by its use the physician may play into the hands of the smooth politician who makes it a policy to ingratiate himself with the public.

"Likewise, the physician should guard against assuming the 'wiser than thou' attitude and talking down to his listeners as if they had not enough intelligence to grasp the significant facts related to a technical subject.

"The physician has right on his side and he need not be vindictive. He is upholding the American way of life; the way of the freedom-loving person who wishes to choose his own plan of action voluntarily and who wishes to have more than an indirect voice in working out his own way of life. Any informed physician can present convincing argument after argument to show that the proposed plans of compulsory health insurance are unsoundly based and will not work.

"The physician can not only afford to keep his temper, but he will do better if he refrains from all display of anger and declines to engage in acrid debate. He certainly is justified in feeling strongly on the subject, but by speaking calmly with assurance, reason and friendliness he is much more apt to make his point and to win over a doubtful listener."

NEWS RE DRUGS

Two items of considerable interest to medical practitioners have been gleaned from *The Indiana Pharmacist* for April, 1949. In regard to the first excerpt, it should be a matter of pride to Hoosiers that the Indiana Food, Drug and Cosmetic Act is a so-called "model act," corresponding to the Federal Act. If you are in active practice you should know the facts set forth below, since we doctors must cooperate with pharmacists and they with us:

"Any packaged drug bearing the prescription legend 'Caution: To be used only by or on the prescription of a physician,' cannot be sold across the counter.

"Now that the Sullivan case has been decided in its favor, the U. S. Food and Drug Administration will resume the institution of proceedings against druggists who violate the 'Rx legend' regulation by over-the-counter sales of drugs bearing the prescription label. The Food and Drug Administration has held in abeyance proceedings involving violations at the retail level, pending the review by the United States Supreme Court of the Sullivan case. However, Food and Drug Administration inspectors continued their checking of retail drugstores for violations of the prohibition against over-the-counter sales of drugs bearing the 'Rx legend.' The U. S. Food and Drug Administration has collected evidence of violations of the 'Rx legend' regulation and, according to Food and Drug Administration officials, prosecutions will be instituted where warranted."

The second "quote" shows what can be done to improve abuses of a given type of drug by employing very simple means. Such results certainly speak well for the integrity of the pharmacists and physicians of our state.

"Traffic in 'sleeping pills' in Indiana has been reduced greatly, T. E. Sullivan, director of the State Health Board's food and drug division reported at the annual meeting of the Central States Association of Food and Drug Officials. . . ."

"Five years ago, he said, sale of sleeping pills had reached 'serious proportions' in the state, but reduction has been brought about by cautioning druggists and 'keeping an eye' on persons who appear to have too many prescriptions for the pills.

"Six deaths in the state were attributed to sleeping pill poisoning in the last year, despite the reduction, Sullivan said.

"He pointed out most illegal sales of sleeping pills in the state result from persons taking advantage of ethical and well-meaning druggists and doctors."

News Notes

A six-day course especially designed for hospitals in the planning stage has been added to the 1949 American Hospital Association Institute schedule.

The Institute on Hospital Establishment will be held on the Chicago campus of Northwestern University from August 8 through August 13. The course was set up to meet a need that seems particularly acute in localities which have not heretofore operated a hospital.

The curriculum is being developed in cooperation with the Hospital Services Branch of the United States Public Health Service's Hospital Facilities Division.

Among topics to be taken up are establishing a budget, determining patient charges, personnel problems, public relations responsibilities, setting up a medical staff and nursing organization, service departments and business procedures.

Applications for attendance at the Institute should be addressed to Mr. Roy Hudenburg, American Hospital Association, 18 East Division Street, Chicago 10, Illinois. Tuition fee is \$35. Reservations can be made for dormitory accommodations on the University's campus.

Enrollment in the Institute on Hospital Establishment is limited to administrators of hospitals in the planning stage, members of the governing boards of such institutions, and representatives of hospitals that are members of the American Hospital Association.

RESEARCH FELLOWSHIPS— THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1950-June 30, 1951. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from \$2,200 to \$3,200. Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than October 1, 1949. Announcement of awards will be made November, 1949.

A postgraduate course in Modern Treatment of Fractures and Other Traumatic Conditions will be given at Massachusetts General Hospital, October 24 to November 3, 1949, under the auspices of the Harvard Medical School. For further information, write: Assistant Dean, Courses for Graduates, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts.

The American Congress of Physical Medicine will hold its twenty-seventh annual scientific and clinical session September 6, 7, 8, 9 and 10, 1949, inclusive, at the Netherland Plaza Hotel, Cincinnati. Scientific and clinical sessions will be given on the days of September 6, 7, 8, 9 and 10, 1949. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 6, 7, 8 and 9. These courses will be offered in two groups. One set of ten lectures will consist of basic subjects, and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapy technicians who are registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2.

AWARD-WINNING ARMY FILM AVAILABLE

The Army Medical Department-Signal Corps "Oscar"-winning motion picture entitled "Toward Independence," is available on a loan basis to all military organizations, and to any nonprofit civilian group. The film may be obtained from the Signal Corps Film Library at Fort Knox, Kentucky, or at Fort Sheridan, Illinois.

The picture portrays the program for the care of paraplegics as developed by the Army Medical Department. The film details the progress of a patient first learning to move about in his hospital bed, then learning to use re-educated muscles in opening doors, climbing stairs, and driving automobiles, and other steps in their rehabilitation.

Although "Toward Independence" was made as a teaching aid in the training of medical personnel, its realism and humanism won for it the annual award of the Academy of Motion Picture Arts and Sciences, as the best documentary film of the year.

INDIANA PRACTICAL NURSES' ASSOCIATION ORGANIZED

The Indiana State Nurses' Association recently assisted the practical nurses of Indiana in organizing a state association. Practical nurse representatives of each of the twelve districts of the Indiana State Nurses' Association met in Indianapolis on April 6, adopted by-laws, and elected officers. Mrs. Rosa Canter of Evansville, a licensed practical nurse from Oklahoma, is president; Mrs. Lyda Henn, of Sunnyside Sanatorium, secretary; and Mrs. Lela Young, of Terre Haute, treasurer.

Active membership in the association is limited to "those who are performing for compensation services in the nursing care of the sick not involving the specialized training of registered nurses." Active members must be licensed in Indiana or some other state, or have had two years of practical nursing experience within the past five years under the supervision of a licensed physician or registered nurse.

Dr. Emmett B. Lamb of Indianapolis was elected president-elect of the Central States Association of Industrial Physicians and Surgeons at the annual meeting in Chicago May 14 and 15. The association, which is a component of the American Association of Industrial Physicians and Surgeons, has a membership of approximately 400 doctors in Indiana, Illinois, Iowa, Minnesota, Wisconsin and Michigan. The association devotes its attention to education and research in industrial medicine.

ARMY OCCUPATION FORCES IN JAPAN NEED PUBLIC HEALTH OFFICERS

The Department of the Army is urgently in need of Public Health Officers to serve in a civilian capacity with the occupation forces in Japan. These positions, which involve supervision of Japanese prefecture (state) health departments in all phases of preventive medicine and medical care programs, offer an excellent opportunity for broad experience in public health.

Minimum acceptable qualification requirements are a degree in medicine plus one year internship. Experience in public health is desirable but is not mandatory.

The salary for these positions is \$6,235.20 per annum plus 10 percent post differential, with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain a minimum of two years. Transportation is furnished to and from Japan. Dependents may join the employee in approximately 6 to 8 months after his arrival in the command.

Interested applicants should make formal application by submitting Civil Service Commission Standard Form 57 to Charles C. Furman, Chief, Recruitment Section, Overseas Affairs Branch, Civilian Personnel Division Department of the Army, Washington 25, D. C. Forms may be obtained from any Class A Post Office.

ISRAELI MEDICAL SCHOOL OPENED IN JERUSALEM, MAY 17, 1949

The Hebrew University - Hadassah Medical School, the first medical school to be established in the new State of Israel, opened its doors May 17, 1949, as a joint undertaking of the Hebrew University and Hadassah, the Women's Zionist Organization of America. Until security conditions permit continuation of construction on Mt. Scopus, the site of the present 400 bed Rothschild-Hadassah-University Hospital, the school will be housed in four hospital units, totalling initially over 300 beds, in the city of Jerusalem proper. During the winter and early spring, Hadassah has been speeding the most modern supplies and equipment for the laboratories and classrooms of the Medical School.

FLUORESCENT LIGHTS

After consultation with officials of the public Health Service, the major manufacturers of fluorescent lights have stated that after June 30, 1949, they will no longer use beryllium phosphor in the manufacture of the fluorescent lights.

For several years the industry has been working with medical men toward eliminating the dangers of beryllium in fluorescent lights. Dr. James G. Townsend, chief of the Public Health Service's division of industrial hygiene, has been serving as chairman of the Medical Advisory Committee on Beryllium to the industry, which also includes the medical directors of the major manufacturers of fluorescent lights.

The announcement of the June 30 deadline for the use of beryllium in the lights came after Dr. Townsend met recently with a group of executives of the major manufacturers of fluorescent lights.

In view of the fact that the manufacturing changeover in eliminating beryllium will take until the end of June, and there is a stockpile of fluorescent lamps already manufactured, the Advisory Committee emphasized again the instructions it has issued in the past concerning the health hazards in the destruction of the fluorescent lights.

The committee reiterated its assertion to the general public that there is no danger whatever from the lights when they are intact.

The possible dangers come in the destruction of old lights. Recently there have been reports of children who cut themselves on broken lights, and that the cuts healed very slowly and often suffered swelling. The Committee repeated, however, its original statement that such cuts do not cause any general sickness or spread further on the body. Surgical care is necessary if the cut refuses to heal after a period of time.

Although precautions should be taken against breathing the dust from broken fluorescent lights, the committee said, there is no record of any person suffering injury from breathing dust from the occasional breakage of a lamp, despite the millions of lights in use.

"Severe intractable asthma

requires more strenuous measures. . . . Aminophyllin in doses of 0.25 Gm. dissolved in 10 cc. of water is often very effective when injected intravenously."¹

To relax spasm, relieve congestion and restore deep, regular breathing,

SEARLE AMINOPHYLLIN*

has proved a valuable drug—generally effective even in epinephrine-refractory cases.

Searle Aminophyllin is indicated in paroxysmal dyspnea, bronchial asthma, Cheyne-Stokes respiration and selected cardiac cases.

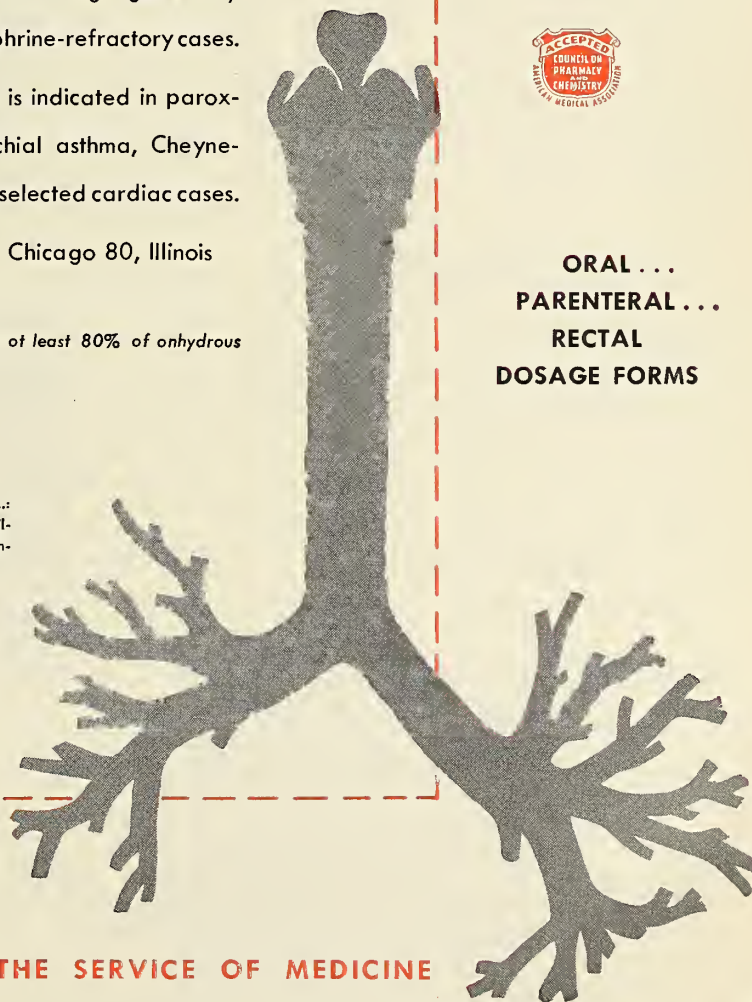
G. D. Searle & Co., Chicago 80, Illinois

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

1. Rackemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.



ORAL . . .
PARENTERAL . . .
RECTAL
DOSAGE FORMS



SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Patronize Your Advertisers

Announcement has been made recently that Owen L. Slaughter, M.D., an internist, has begun practicing in Evansville. He is associated with Drs. George Willison and Patrick J. V. Corcoran, at 118 South First Street. Doctor Slaughter is a native of Nebraska and a graduate of Nebraska University Medical School in 1943. He interned at St. Louis University Group Hospitals and was in general practice in St. Louis for six months. He then went to the Mayo Clinic in Rochester, Minnesota, as a fellow in internal medicine.

The 21st Annual Meeting of the Indiana Roentgen Society was held May 15 at the Indianapolis Athletic Club. It was an all day meeting held under the Presidency of Dr. Arthur P. Echternacht, Culver Hospital, Crawfordsville. The banquet in the evening was attended by 89 members and guests, and was addressed by Dr. L. R. Sante, Professor and Head of the Department of Radiology, St. Louis University Medical School. His subject was "Microscopic Pathology: The Key to Roentgen Findings in Pulmonary Diseases."

The following officers of the society were elected for 1949-50: president, Clifford C. Taylor, M. D., St. Vincent's Hospital, Indianapolis; vice-president, J. A. Campbell, M. D., Indiana University Medical Center, Indianapolis; secretary-treasurer, William M. Loehr, M. D., 712 Hume Mansur Building, Indianapolis. Kenneth Olson, M. D., of South Bend, became Chairman of the Society's Executive Committee.

AIR SURGEON INITIATES GENERAL PRACTICE BRANCH

Air Surgeon Major General Malcolm C. Grow has announced the initiation of a General Practice Branch in the Air Surgeon's office, to be charged with the development of training opportunities and careers for general practitioners serving at USAF installations.

According to current Air Force organization, approximately 70 percent of physicians serving with USAF units are general practitioners. Of the remainder, 5 percent are staff and administrative personnel and 25 percent are specialists.

Initiation of the new General Practice Branch was considered imperative by General Grow, who characterized the general practitioner as the backbone of the Air Force medical service.

Under the new program the general practitioner will be enabled to enter into a proposed residency program to be operated in the General Hospital setup. The residency program will offer the general practitioner access to latest technical developments in medical and surgical specialties. Special emphasis will be placed on internal medicine, surgical practices, pediatrics and obstetrics.

The new General Practice Branch will work cooperatively with the Surgeon General's career program for medical officers.

James Alford, M.D., of Hamilton, expects to divide his time between Pleasant Lake and Hamilton, where he resides and maintains an office. Doctor Alford was in the navy during World War II, and has been practicing in Hamilton for the past year.

TRAINING COURSE IN POLIOMYELITIS

The Department of Contagious Diseases of the City Hospital of Cleveland offers training courses in poliomyelitis, to physicians, nurses and physical therapists. The material presented is of practical value. There is no tuition fee. The cost of traveling expenses, room and meals may be borne by the enrollee, the organization with which he is affiliated, or his local chapter of The National Foundation for Infantile Paralysis.

The physicians courses are scheduled for July 18 to July 23, inclusive; August 8 to August 13, inclusive; and August 28 to September 3, inclusive.

Immediate enrollment is urged. Application blanks may be obtained from John A. Toomey, M. D., 3395 Scranton Road, Cleveland 9.

Britain's National Health Service is not all good, nor is it all bad, according to Associate Editor Steven M. Spencer, who reports on his five weeks' investigation of the plan in the May 14th *Saturday Evening Post*. His article, "How Britain Likes Socialized Medicine," is the first of three.

British working men and women have traditionally been less able to pay for medical and dental care than Americans, Mr. Spencer points out. So the result of socialized medicine has been a rush to doctors, dentists and opticians at a cost of \$1,200,000,000 a year, most of which comes from general taxes.

Three main functional faults of the plan, Mr. Spencer says, are these: 1) the doctors are being overworked; 2) dentists, opticians and druggists are making too much money; 3) many people are abusing the opportunity to have doctoring without doctor bills.

"Least happy about the whole thing are the doctors," Mr. Spencer writes. "Most of them feel the Labor government forced them to swallow too big a dose of state medicine at one time, and that it now expects them to cure their own economic indigestion. Many are working twice as hard for half or even a tenth as much money as they made before last July 5, and are being forced to borrow to meet household bills. . . ."

The national health service unlocks the door to preventive medicine in Britain, which has the approval of most doctors, Mr. Spencer says. But one doctor pointed out that there isn't time to look for early symptoms with a waiting room full of patients to be treated for late symptoms.

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 - * Similac fat has been so altered
 - * Similac minerals have been so adjusted
- that*
- * There is no closer approximation to
mother's milk.

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0 grams
truly a fluid food



curd of breast milk —
0 grams
truly a fluid food

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curd of
powdered milk
especially prepared
for infant feeding —
12 grams

COLUMBUS 16, OHIO

Paul Bergen, M.D., who has been associated with John Mirro, M.D., in Lowell for the past two years, is now located at Beaver Dam, Wisconsin, where he has taken over an established practice.

Announcement was made recently that Charles W. Atkinson, M.D., of Boswell, will open an office in Pine Village, to be open two days a week.

Governor Henry F. Schricker recently appointed a seven-member Indiana Tuberculosis Council to aid the State Board of Health in the treatment and care of tuberculosis. The Council was established by the 1949 General Assembly. Appointed to the council are Dr. Warren S. Tucker, Indianapolis, one year; Dr. Thomas R. Owens, Muncie, one year; Dr. John R. Matthews, North Judson, two years; Murray A. Auerbach, Indianapolis, executive secretary, two years; Robert O'Bannon, Corydon, four years; Custis Hostetter, Lafayette, four years; and Dr. L. E. Burney, state health commissioner, ex-officio member, who shall have the rights of any other council member.

The Vanderburgh County Medical Society has approved the report of a committee appointed by Dr. George Willison, president, to explore the possibilities of a diabetic survey in the community. Drs. Harold D. Lynch and L. Paul Hart were named by Dr. Willison to serve with Dr. W. A. Browne, health director. Others named by Dr. Willison to serve on the committee were: Dr. S. L. Bryan, chairman; Dr. Julian Present, Dr. Paul Clouse, Dr. Albert Ritz, and Dr. R. H. Schirmer. Its purpose is to determine the incidence of diabetes, and to reach possible unknown diabetics so they may be advised of necessary treatment.

Announcement has been made by Roy Kinzer, president of the board of directors of the Wabash Valley Sanitorium, of a new hospital administrator, J. Moss Beeler, M.D. Doctor Beeler comes from the New York Medical College and Flower and Fifth Avenue Hospitals, where he was administrator for the entire institution. Doctor Beeler was born and educated in Kentucky and received his medical degree from the Medical College of Louisville. He is a fellow of American Psychiatrists and a fellow of American College of Hospital Administrators.

Ritchie Coons, M.D., who has completed his internship in the Huron Road Hospital, East Cleveland, Ohio, recently joined his father, Dr. John D. Coons, in the practice of medicine at Lebanon, the third generation in the family to serve the medical needs of that community continuously over a period of 65 years. Dr. Henry N. Coons and Dr. John D. Coons were graduates of Wabash College, and Dr. Ritchie Coons studied there for three years, finishing his pre-medical course at the University of Chicago.

John E. Mackey, M.D., of Rockport, has been appointed to the staff of the Indiana General hospital, Indianapolis, and will begin his duties there July 1. He will complete his graduate work in obstetrics and gynecology. He is a graduate of the Indiana University School of Medicine, and served his internship at Methodist Hospital, Indianapolis. He also completed one year of graduate work before entering the Army, where he served for two years with the U. S. Medical Corps.

Deaths

Byron H. Boone, M.D., died at his home near Shelbyville on May 19. He was eighty-four years of age. A graduate of the Kentucky School of Medicine, in Louisville, in 1894, Doctor Boone practiced in Boggstown for seventeen years, and then moved to Acton, where he practiced until he retired.

Herman H. Kamman, M.D., of Columbus, died

suddenly May 20, at the age of seventy-seven. He had practiced in Columbus for more than forty-five years. Doctor Kamman was a graduate of the Kentucky School of Medicine of Louisville, in 1903. He was an honorary member of the Bartholomew-Brown County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



The psychosomatic price

The tensions of modern living demand a price that is frequently gastrointestinal injury, occasionally peptic ulcer. The prevention and cure of peptic ulcer embrace the application of hygienic, psychiatric, dietary, and therapeutic techniques to this problem.

Logically, therapy should include the administration of materials which will tend to reduce the acidity

of the gastric content without producing alkalosis or other undesirable effects. Coincidentally, a demulcent effect should be sought to coat the ulcerated surfaces and protect them from erosion. *Lederle* research has found that a casein, low in sodium, high in calcium, in appropriate form, when given by mouth will accomplish these ends and provide the patient with prompt symptomatic relief.

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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

May 22, 1949.

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; A. P. Hauss, M.D., C. S. Black, M.D., Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; Ray E. Smith, and J. A. Waggener.

Membership Report

Number of members May 17, 1949-----	3,625*
Number of members May 17, 1948-----	3,565
Gain over last year-----	60
Number of members Dec. 31, 1948-----	3,687
* Includes 35 in military service (gratis)	
187 honorary members	

Treasurer's Office

(1) *St. Paul-Mercury Indemnity Company.* The treasurer reported that the St. Paul-Mercury Indemnity Company would employ the association's counsel for defense in event a member insured by it is sued for malpractice, and suggested that the St. Paul-Mercury Indemnity Company be asked to circularize the membership setting out this fact. By consent it was decided to bring the matter to the attention of the Council on July 31.

(2) *Check signatures.* On motion of Drs. Black and Hauss, the committee voted to require signatures of the treasurer and the chairman of the Council only on checks after the present supply of printed checks is exhausted.

Statements of receipts and expenditures for April for the association and *THE JOURNAL* were approved.

1949 Annual Session, Indianapolis, September 26-29, 1949

On motion of Drs. Portteus and Black, the committee decided to use picture and biographical data of the speaker at the Indiana Academy of General Practice luncheon, inasmuch as he is also being invited to address the House of Delegates.

On motion of Drs. Portteus and Ellison, the executive secretary was instructed to invite the Governor of Indiana and the Mayor of Indianapolis to the annual banquet on September 29, 1949.

Election by Bartholomew-Brown County Medical Society of Dr. K. D. Schneider as a delegate to the House of Delegates was approved by consent. Although Dr. Schneider practices part-time in Morgantown, Morgan county, he maintains his residence in Nashville, Brown county.

Legislative Matters

National

On motion of Drs. Portteus and Ellison, the committee went on record as opposing in principle the use of federal funds for examination and treatment of school children as provided in S. 1411 and H. R. 3942. In the event of the passage of these bills, the committee approved the appointment of a special medical commission in Indiana to administer the program in cooperation with the Indiana State Board of Health.

The committee recommended that the chairman write a letter to Senator William E. Jenner, thanking him for his recent letter to members of the association setting forth his opposition to the proposed national health insurance bills.

A.M.A. National Education Campaign

The chairman of the A.M.A. Campaign Coordinating Committee reported on progress of the campaign in Indiana, pointing out that Mr. Whitaker of Whitaker & Baxter, director of the National Educational Campaign for the A.M.A., had announced that Indiana is doing one of the best jobs.

A series of advertisements against compulsory health insurance, submitted by the National Sales Foundation of Dallas, Texas, for approval, was "approved in principle," particularly the plan for pharmacists to sponsor such type of advertising.

Organization Matters

Change in name of Committee on Rural Medical Care. The committee agreed to changing the name of the Committee on Rural Medical Care to Committee on Rural Health, to conform to the A.M.A. terminology.

Painting of Dr. Livingston Dunlap. On motion of Drs. Hauss and Portteus, Dr. John Eric Dalton's offer of a painting of Dr. Livingston Dunlap, president of the Indiana State Medical Society in 1849, as a gift to the association was accepted.

Approval of letter and folder of Indiana Mental Hygiene Society. The executive secretary reported that a mail poll of committee members on the revised letter and folder the Indiana Mental Hygiene Society proposed to send to members of the association resulted in unanimous approval.

Invitation to participate in Annual Summer Conference at Purdue. The committee accepted an invitation for the association to participate in the annual Summer Conference at Purdue University, August 2, 3 and 4, 1949, and directed the executive secretary and field secretary to prepare an exhibit financed by funds of the Indiana A.M.A. Campaign Coordinating Committee.

Nominations for A.M.A. Associate Fellowships. On motion of Drs. Ellison and Black, the committee approved the nomination of fourteen honorary members of the state association for associate fellowship in the A.M.A.

The executive secretary reported that Francis M. Overstreet, director of concessions for the 1949 Indiana State Fair, had assured him that medicine men will not be permitted at the 1949 State Fair.

Lake County special memberships. As the by-laws of the Indiana State Medical Association do not prohibit county medical societies from setting up special memberships, the committee saw no objection to the Lake County Medical Society creating a special membership for physicians of nearby counties who wish to participate in the Lake county group health and accident insurance plan.

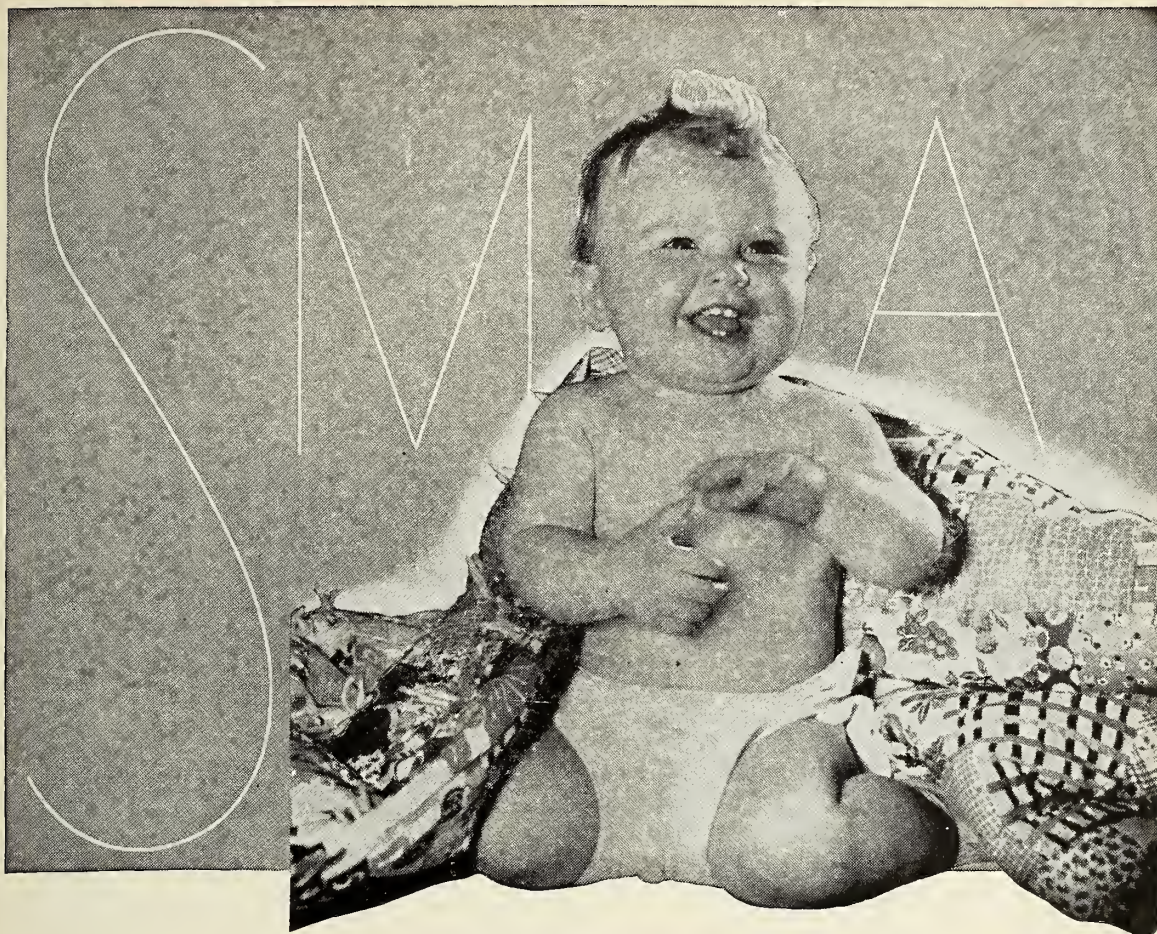
On motion of Drs. Portteus and Hauss, the committee approved a request from the Norways Foundation for use of the association's mailing list to send a letter and news release to the membership.

Use of I.S.M.A. membership mailing plates restricted. On motion of Drs. Hauss and Ellison, the use of the association's membership mailing plates by any individual or group for commercial purposes was denied.

On motion of Drs. Hauss and Portteus, the field secretary was authorized to attend the A.M.A. meeting in Atlantic City for three days.

Insurance

Request from the executive committee of the Indianapolis Accident and Health Association that Noel Iiams, one of its members, be granted a hearing at the next meeting of the committee, was granted, on motion of Drs. Portteus and Ellison.



ESSENTIALLY THE SAME AS HUMAN MILK IN ALL VITAL NUTRIENTS

In S-M-A the **amino acid** content—the growth-promoting factors, methionine and tryptophane included—is as high as the peak values for these amino acids in human milk . . .

vitamin content (including **vitamin C**) equals or exceeds minimum daily requirements . . .

minerals compare favorably with those of human milk . . .

fat—the iodine number (index of **unsaturated fatty acids**) for S-M-A fat is standardized at the top of the range found in human milk.

The percentage of linoleic acid (14.4) and linolenic acid (0.4) in the total S-M-A fat compares well with the same values for human milk.

S-M-A builds husky babies



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Letter from the Farm Bureau Insurance Service asking help in drafting a new medical payment schedule was referred to a committee composed of Drs. Kennedy, Portteus, Weyerbacher, Ellison, Howard, Clark, Ferrell and Dodds, who comprise the Executive Committee of the Mutual Medical Insurance, Inc.

Letter from Dr. Charles E. Gillespie to the effect that he is proceeding with formation of an automobile insurance company, exclusive for physicians and dentists, was read.

The Journal

Report on advertising:

Increase to May 22, 1949-----\$ 184.80
No decreases
Total increase for year-----\$2,182.30

Request of Eli Lilly and Company, through the Co-operative Medical Advertising Bureau of Chicago, for purchase of advertising space on the front cover of THE JOURNAL was refused, on motion of Drs. Ellison and Hauss.

There being no further business, the committee adjourned to meet again at 7:00 p.m., Saturday, June 25, at the Columbia Club.

COMMITTEE ON PUBLICITY

April 22, 1949.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D., and Ray E. Smith, executive secretary.

The committee voted to make a survey of all county medical societies to learn how many are providing round-the-clock medical service in their communities.

The executive secretary reported that reaction to the proposed radio transcriptions had been good thus far, but only a few county societies had responded to the announcement.

Substitution of "That Wonderful Feeling" for the radio series "Live and Like It," as ordered by the committee, was reported. The American Medical Association's Bureau of Health Education said "Live and Like It" was no longer available.

Speaking engagements: April 25, 1949—Lions Club, Franklin, "Pills and Politics," association attorney. April 25, 1949—Delta Upsilon Alumni Association, Indianapolis, "Political Medicine," executive secretary.

May 6, 1949.

Present: James O. Ritchey, M.D., chairman; Homer Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and Larry Richardson, field secretary.

Cards received in the survey of county medical societies on whether they have round-the-clock medical service were reviewed.

The following "Hints on Health" column was approved: Week of June 13, 1949, "Spotted Fever."

The executive secretary reported the number of orders for pamphlets against compulsory health insurance received to date from samples mailed to the association membership.

The committee approved preparation of an article on Indiana physicians' participation in the annual American Medical Association convention at Atlantic City for release to the press.

The executive secretary reported that few county societies had indicated their willingness to buy radio time for a series of transcriptions against socialized medicine proposed by the committee.

COUNCILOR DISTRICT MEETINGS

FIRST DISTRICT

Dr. Willard T. Barnhart of Evansville was elected president of the First District Medical Society at the annual meeting, May 26, which was held in connection with the graduate education program at Evansville College. Dr. William O. Denzer, also of Evansville, was elected vice-president, and Dr. William B. Challman of Mt. Vernon was elected secretary. Dr. Barnhart succeeds Dr. Virgil McCarthy of Princeton as president. Dr. Herman T. Combs, First District Councilor, gave a report of state association activities.

SECOND DISTRICT

The Second District Medical Society met in the afternoon of June second at the New Country Club House of the Sullivan Elks Club. Every county in the district was represented and about fifty members were present.

In a short business session Dr. J. S. Brown of Carlisle was re-elected secretary and Knox County was chosen as the place for the next meeting. The members of the Knox County Medical Society will choose the district president at their next regular meeting of that Society.

The afternoon program was furnished by the staff of The Indiana State Board of Health. Dr. L. E. Burney, State Health Commissioner, discussed the relationship of the State Board of Health to the Medical Profession. Dr. W. C. Anderson, Director of the Division of Gerontology and Chronic Diseases, talked on some aspects of the cancer problem. Dr. Merle Bundy, Director of Tuberculosis Control, discussed mass case-finding techniques in tuberculosis.

The talks were interesting and well received. Dr. W. C. Reed, District Councilor, spoke on his work in the Council. The Indiana State Medical Association was represented by Dr. C. S. Black, President-Elect. Dr. Black got an enthusiastic welcome and made an earnest plea for all doctors, in this time of trial, to meet fully all of their duties and obligations to the people.

The evening was finished by an old fashioned chicken dinner furnished by the Sullivan County Medical Society.

THIRD DISTRICT

Dr. Ernest P. Buckley of Jeffersonville was elected president, and Dr. Eli Goodman of Charlestown was elected secretary-treasurer of the Third District Medical Association meeting held at Corydon on May 25. Jeffersonville was selected as the place for the 1950 meeting.

Dr. William H. Garner of New Albany was re-elected to the three-year councilor term.

Dr. A. P. Hauss of New Albany, president of the Indiana State Medical Association, was a guest at the meeting.

Doctor Hauss spoke on the early history of Indiana Medicine and the important part played by the early physicians in the Third District. He presented a copy of the original diary of Dr. Asahel Clapp of New Albany, who was the first president of the original State Medical Society in Indiana, which was organized in Corydon in 1820. Doctor Clapp was also president of the present state medical Association in 1850.

Doctor Hauss spoke of the advantages of county society plans for around-the-clock medical care and stated that a majority of the counties have now adopted some type of plan.

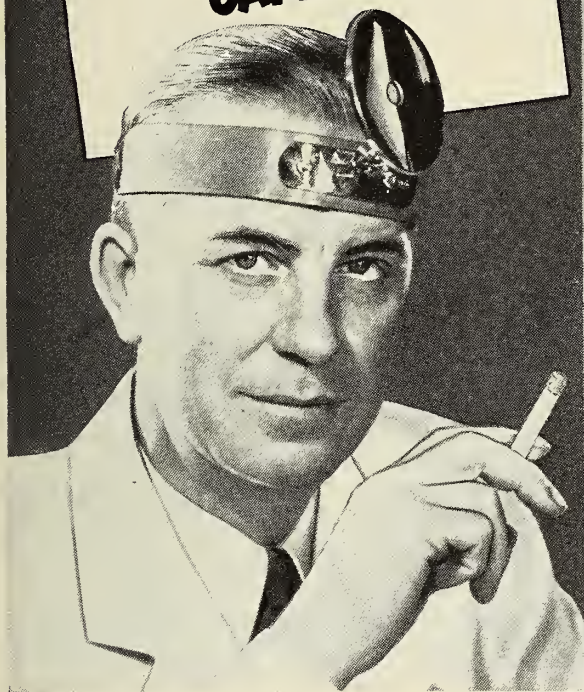
Presiding at the meeting was Dr. William E. Amy of Corydon, president of the association.

How mild can a cigarette be?

DOCTORS REPORT

In a recent test of hundreds of people who smoked only Camels for 30 days, noted throat specialists, making weekly examinations, reported

"NOT ONE SINGLE CASE OF THROAT IRRITATION DUE TO SMOKING CAMELS!"



SMOKERS REPORT

"I MADE MY OWN PERSONAL 30-DAY TEST! NOW I KNOW—CAMELS ARE THE MILDEST, BEST-TASTING CIGARETTE I EVER SMOKED!"

Sylvia Mac Neill

SECRETARY



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

According to a Nationwide survey:

More Doctors smoke Camels
than any other cigarette

Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel

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FOURTH DISTRICT

Dr. Dale D. Dickson of Greensburg was elected president of the Fourth District Medical Society at the 1949 meeting held at the Dearborn Country Club near Aurora on May 25. Dr. Benet W. Thayer of North Vernon was elected vice-president and Dr. Charles Overpeck of Greensburg was elected secretary. Greensburg was selected as the place for the next meeting.

Winners in the golf tournament were Drs. George A. May of Madison, Dennis W. Matthews of North Vernon, Leslie M. Baker of Aurora, George Vail of Lawrenceburg, and George M. Brother of Indianapolis, a guest.

The following scientific program was presented in the afternoon: "The Cause and Treatment of Hemolytic Disease of the Newborn," by Sister Eugene Marie, Good Samaritan Hospital of Cincinnati; "Menorrhagia Due to Endocrine Disturbances," by Dr. Paul Muller of Indianapolis; "Analysis of One Hundred Cases of Gross Hematuria," by Dr. John W. Hauser of Cincinnati, and "Management of Common Fractures," by Dr. Elsie Asbury of Cincinnati.

The wives were taken through the Schenley Penicillin Laboratories and entertained at tea. The H. and S. Pogue Co. of Cincinnati presented an interior decoration program.

Speakers at the banquet were Ray E. Smith, executive secretary of the Indiana State Medical Association, and Ollie M. James, chief editorial writer and columnist of *The Cincinnati Enquirer*, widely-known humorist.

Dr. Charles N. Manley of Rising Sun, society president, presided at the sessions. Doctor May, councilor, presented his annual report at a luncheon meeting of the delegates. Dr. O. H. Stewart of Aurora was in charge of golf. Mrs. J. M. Pfeifer of Lawrenceburg had charge of the entertainment for the wives, and Dr. J. Kenneth Jackson of Aurora, was program chairman.

FIFTH DISTRICT

Approximately sixty physicians attended the Fifth Councilor District Medical Society meeting at The Elks Club in Brazil on Wednesday, May 25. Officers elected for the coming year are as follows: president, M. C. Topping, M.D., Terre Haute; vice-president, C. Harstad, M.D., Rockville; secretary, Stuart R. Combs, M.D., Terre Haute.

The scientific program during the afternoon consisted of the following presentations: "External Fixation of Fractures," by Dr. Irvin H. Scott, of Sullivan; "The Management of Labor," by Dr. Carl P. Huber, Indianapolis; "Management of Diabetes," by Dr. J. H. Warvel, of Indianapolis.

Dr. Warren F. Draper, of Washington, D.C., delivered the main address of the evening. Doctor Draper, who is the medical director of the United Mine Worker's Health and Welfare Fund, presented the plans and explained the workings of the program. Doctor Draper pointed out that the help from the individual physicians in all sections of the country had greatly facilitated their program. Physicians everywhere have taken a keen interest in the program and have been most valuable in working toward a satisfactory solution of the health problems that face miners and their families. He stated that the starting of the fund was made necessary due to the fact that miners, as risks, were rated 277 percent higher than workers employed in nonhazardous industry. Since the beginning of the program the fund has provided treatment for over twenty thousand miners' dependents for a total in excess of sixty thousand days of hospital care. A comprehensive program is planned for furnishing complete hospital and medical service for all miners and their entire families. This will include payment for house and office calls.

In conclusion, Doctor Draper invited questions from those in attendance and requested that the doctors dis-

cuss, either with the Washington or the Louisville area office, at any time the problems they might face in giving the miners and their dependents the best in medical care.

Guests introduced included Dr. Asa Barnes, Louisville, area medical director of the U.M.W. program; Mr. R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc., Indianapolis, and James A. Waggener, field secretary of the Indiana State Medical Association.

EIGHTH DISTRICT

The annual meeting of the Eighth District Medical Society was held at the Delaware Country Club in Muncie, on May 18, with eighty physicians in attendance. Joseph H. Clevenger, M.D., president, presided and introduced the following guests: W. U. Kennedy, M.D., New Castle, councilor for the sixth district, and James A. Waggener, field secretary.

Officers elected for 1949-50, were I. E. Brenner, M.D., Winchester, president, and Benjamin F. Wills, M.D., Union City, secretary. The 1950 meeting will be held in Muncie at the Delaware Country Club, due to its central location for those in the district.

An excellent and informative scientific program was presented, as follows: "The Conservative Management of Low Back Ache," by Dr. Frederick Brown, Fort Wayne; "The Neurologic Aspects of Low Back Pain," by Dr. Robert L. Glass, Indianapolis, associate professor of surgery and head of neurosurgery at Indiana University Hospitals; "Diseases of the Mouth," by Dr. Russell A. Sage, of Indianapolis.

Following the dinner Dr. E. H. Clauser, Muncie, gave his councilor report. Dr. Augustus P. Hauss, New Albany, president of the Indiana State Medical Association, delivered the main address of the evening, pointing out that the responsibility for good medical care and good public relations was right back home. He concluded with an appeal for the establishment of round-the-clock medical service in every community.

ELEVENTH DISTRICT

Dr. Frederick M. Whisler of Wabash was elected president, and Dr. O. G. Brubaker of North Manchester was re-elected secretary-treasurer at the spring meeting of the Eleventh Indiana Councilor District Medical Society in Logansport on May 18. The fall meeting will be held in Delphi on Wednesday, September 21.

Doctor Brubaker has served as secretary-treasurer of the district group since 1927.

Dr. Elton R. Clarke of Kokomo, who has been acting as councilor by appointment of the Scientific Committee, was formally elected councilor. He will fill the unexpired term of the former councilor, Dr. Claude S. Black of Warren, now president-elect of the Indiana State Medical Association.

A resolution urging Congressman John R. Walsh, of the Fifth Congressional District, to oppose compulsory sickness insurance was adopted.

The scientific program consisted of a discussion of various aspects of tropical diseases. The discussants were Drs. John R. Brayton, J. L. Arbogast and James S. Browning, all of Indianapolis, and Dr. L. T. Coggeshall of Chicago.

The wives were entertained at a bridge-tea at the Logan Club while the scientific program was in progress. The Rev. B. F. Schumacher, pastor of the St. James Lutheran Church of Logansport, presented a ceramics and pottery exhibit.

The physicians joined their wives for dinner in the Logan Club in the evening. Brief talks were made by Doctor Black and Ray E. Smith, executive secretary of the Indiana State Medical Association. A musical program was later enjoyed by the eighty-one persons at the dinner.

in hay fever...

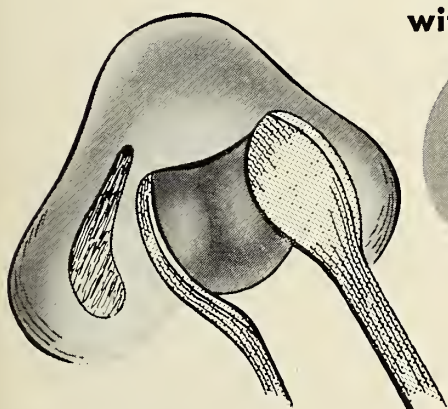
- ...Nasal Engorgement Reduced
- ...Soreness, Congestion Relieved
- ...Aeration Promoted
- ...Drainage Encouraged

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NEO-SYNEPHRINE®

HYDROCHLORIDE

Brand of
Phenylephrine Hydrochloride



When Neo-Synephrine comes in contact with the swollen, irritated mucous membrane of the nose, the patient soon experiences relief.

This powerful vasoconstrictor acts quickly to shrink engorged mucous membranes, restoring easy breathing, and promoting free drainage.

The prolonged effect of Neo-Synephrine makes fewer applications necessary for the relief of nasal congestion — permitting longer periods of comfort and rest.

Neo-Synephrine does not lose its effectiveness on repeated application . . . It may be employed with good results throughout the hay fever season . . . It is notable for relative freedom from sting and absence of compensatory congestion . . . Virtually no systemic side effects are produced.

Supplied as:

¼% and 1% in isotonic saline solution—1 oz. bottles.

¼% in aromatic isotonic solution of three chlorides—1 oz. bottles.

½% water soluble jelly—½ oz. tubes.



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NEW YORK 13, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U. S. & Canada

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

ALLEN COUNTY (Fort Wayne) MEDICAL SOCIETY
President, A. P. Hattendorf, Fort Wayne,
Vice-President, Paul L. Stier, Fort Wayne,
Secretary, S. C. Michaelis, Fort Wayne,
Treasurer, G. A. McDowell, Fort Wayne.

Boone County Medical Society members held a meeting at the Witham Hospital, in Lebanon, on April 5. Dr. Palmer Eicher, of Indianapolis, spoke on "Disorders of the Foot." Fifteen members were present.

Another meeting was held on May 10. This was the final business meeting of the year. Seventeen members were present.

Fayette-Franklin County Medical Society members held a meeting at the Country Club in Connersville, on May 10. Dr. David L. Adler, of Columbus, spoke on "Cystology as a Diagnostic Aid in Early Cancer." Dr. W. C. Anderson, of the Indiana State Board of Health, also addressed the meeting. Twelve members were present.

Greene County Medical Society members held a meeting at the Freeman Greene County Hospital, in Linton, on May 12. Dr. William C. Reed, of Bloomington, spoke on "Medical Practice and the Future." Seventeen members were present.

Hamilton County Medical Society members met in Sheridan on May 10. Dr. Carl Martz, of Indianapolis, was the guest speaker. His subject was "Reconstructive Surgery."

Howard County Medical Society members held a meeting at Kokomo on May 6. Dr. Marvin Cuthbert, of Indianapolis, spoke on "Neurology of the Third Cranial Nerve and Pupillary Reaction." Twenty-five members were present.

Madison County Medical Society members held a meeting at Manges Cafeteria, in Elwood, on May 23. Dr. Kenneth Kohlstaedt, of Indianapolis, was guest speaker. His subject was "The Treatment of Congestive Heart Failure." Thirty-two members and several out-of-town guests were present.

Montgomery County Medical Society members held a meeting at the Crawford Hotel, in Crawfordsville, on May 19. Dr. H. G. Kobrak, of Chicago, spoke on "Problems of Deafness." A movie was also shown on "The Ear in Health and Disease." Twenty-six members were present.

Owen-Monroe County Medical Society members held a meeting at the Bloomington Country Club on May 27. The guest speaker was Mr. Harry E. Northam, executive secretary of the Association of American Physicians and Surgeons. The society voted for a unanimous endorsement of the principles of that association.

Putnam County Medical Society members held a meeting at the College Inn, in Greencastle, on May 13. Dr. B. K. Rust, of Indianapolis, was the guest speaker. His subject was "Newer Antibiotics in Pediatric Therapy." Fifteen members were present.

Tippecanoe County Medical Society members held a meeting at Colburn School Building, in Colburn, on May 10. Dr. Walter J. Reich, of the Cook County Hospital, Chicago, was the guest speaker. His subject was "Diagnosis and Management of Gynecological Cases as We See Them." Fifty-five members were present.

Wells County Medical Society members held a meeting at the Bluffton Country Club, in Bluffton, on March 21. There were 15 local members, 18 visitors, and their wives were present. This was a joint meeting with the Woman's Auxiliary of the County Society in honor of Dr. Claude S. Black, president-elect of the Indiana State Medical Association, and Mrs. W. R. Morrison of Kokomo, president of the Woman's Auxiliary for the state.

Dr. Black gave an address regarding the present standing of organized medicine. Mr. Lloyd Mattice of Indianapolis, who was a defense attorney at the Japanese War trials, gave a talk on conditions in Japan.

Another meeting of the Wells County Society was held at the Caylor-Nickel Clinic on April 18. Miss Eloise Fellows, the County Health Nurse, gave a report on the various health activities in the county. Plans were made for the Fall Clinical Conference of the Society, to be held on October 12, 1949.

Vanderburgh County Medical Society members held a meeting on May 10 at the Hotel McCurdy, in Evansville, when more than one hundred members were present. The speaker of the evening was Mr. Harry E. Northam, of Chicago, executive secretary of the American Association of Physicians and Surgeons. This was the opening of the county-wide educational program.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT — MAY 1949

Diseases	May 1949	Apr. 1949	Mar. 1949	May 1948	May 1947
Brucellosis	2	7	3	11	11
Chickenpox	196	613	561	286	268
Conjunctivitis, catarrhal	7	13	13	0	0
Diphtheria	16	29	32	55	13
Dysentery, Amebic	1	1	0	1	0
Encephalitis	5	2	2	3	2
Erysipelas	4	0	1	2	0
Food infection	1	0	0	0	0
Impetigo	3	1	1	1	5
Measles	596	1146	582	3920	478
Meningitis,					
Unclassified	4	8	3	5	3
Meningococcal	2	2	2	2	9
Pneumococcal	1	3	1	0	1
Tubercular	1	0	0	0	0
Streptococcal	1	0	0	0	0
Mumps	173	339	184	565	97
Pneumonia	16	55	60	16	28
Polioomyelitis,					
Paralytic	1	1	2	3	2
Non-paralytic	1	1	1	3	0
Rabies in animals	94	95	75	142	--
Rheumatic fever	4	6	1	1	0
Rocky Mt. Spotted Fever	2	0	0	1	3
Rubella	425	419	85	76	6
Scarlet fever	132	309	394	170	251
Septic Sore throat	8	0	9	2	20
Tetanus	1	1	0	3	1
Tuberculosis,					
Pulmonary	208	216	171	204	220
Other forms	11	10	19	17	12
Tularemia	1	6	4	0	1
Typhoid fever	3	5	5	4	1
Whooping cough	47	82	73	99	171

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

AN URGENT APPEAL TO YOUNG DOCTORS!



Your personal help is needed to avert a serious threat to our national security!

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

Normal procurement channels will not provide sufficient replacements!

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, and who saw no active service, to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

Volunteer now for active duty. You are urged to contact the Office of Secretary of Defense by collect wire immediately, signifying your acceptance and date of availability. Your services are badly needed. Will you offer them?

Louis Johnson

Books

BOOKS RECEIVED

NUTRITION AND DIET IN HEALTH AND DISEASE

—By James S. McLester, M.D., Professor of Medicine, University of Alabama, Birmingham. New, 5th Edition. Cloth. 800 pages. Price \$9.00. W. B. Saunders Company, Philadelphia, 1949.

THE AMERICAN NURSES DICTIONARY—The Defi-

nition and Pronunciation of Terms in the Nursing Vocabulary: By Alice L. Price, B.S., R.N., Instructor in Nursing Arts at Columbia Hospital, Milwaukee. 656 Pages. Cloth. Price \$3.75. W. B. Saunders Company, Philadelphia and London, 1949.

GERIATRIC MEDICINE—The Care of the Aging

and the Aged. By Edward J. Stieglitz, M.D., Attending Internist, Suburban Hospital, Bethesda, Maryland; Doctor's Hospital, Washington, D. C. New, Second Edition. 773 pages, with 180 figures. Cloth. Price \$12.00. W. B. Saunders Company, Philadelphia and London, 1949.

PSYCHOSOMATIC MEDICINE—The Clinical Appli-

cation of Psychopathology to General Medical Problems: By Edward Weiss, M.D., professor of Clinical Medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M.D., professor of Psychiatry, Temple University Medical School, Philadelphia. New. Second Edition. 803 pages. Cloth. Price \$9.50. W. B. Saunders Co., Philadelphia and London, 1949.

ORAL AND DENTAL DIAGNOSIS—With Sugges-

tions for Treatment: By Kurt H. Thoma, D.M.D., F.D.S.R.C.S. Eng., professor of Oral Surgery, Emeritus, and Brackett Professor of Oral Pathology, Harvard University. With contributions by Henry Goldman, D.M.D., head of the Dental Department, Beth Israel Hospital, Boston; Fred Trevor, D.M.D., formerly instructor in Oral Pathology, Harvard Dental School. New. Third Edition. 563 pages with 776 illustrations, 60 in color. Cloth. Price \$9.50. W. B. Saunders Co., Philadelphia and London, 1949.

THE YEARBOOK OF PSYCHOANALYSIS. By Sandor

Lorand, M.D., New York, Managing Editor, Henry Elden Bunker, M.D., New York, Ernest Jones, M.D., London, Bertram D. Lewin, M.D., New York, C. P. Oberndorf, M. D., New York, Editorial Board. 356 pages. Cloth. Price \$7.50. International Universities Press, Inc., New York.

HOW TO BECOME A DOCTOR—A complete guide to

the study of medicine, dentistry, pharmacy, veterinarian medicine, occupational therapy, chiropody and foot surgery, optometry, hospital administration, medical illustration, and the sciences: By George R. Moon, A.B., M. A., Examiner and Recorder, University of Illinois Colleges of Medicine, Dentistry and Pharmacy. 131 pages. Cloth. Price \$2.00. The Blakiston Company, Philadelphia 5, Pennsylvania.

MEDICINE THROUGHOUT ANTIQUITY—An historical resumé of medicine as it was conceived, developed and practiced by the various peoples of antiquity: By Benjamin Lee Gordon, M.D., member of American Association of the History of Medicine and American Academy of Ophthalmology and Otolaryngology, 840 pages. 157 illustrations. Cloth. Price \$6.00. F. A. Davis Company, Philadelphia 3, Pa.

BOOKS REVIEWED

PRACTICAL ASPECTS OF THYROID DISEASE. By

George Crile, Jr., M.D., Department of Surgery, Cleveland Clinic. 355 pages with 101 figures. Cloth. Price \$6.00. W. B. Saunders Company, Philadelphia and London, 1949.

This volume presents a concise, but very complete discussion of the present day concepts of thyroid diseases and their treatment. As stated in the preface, it "is designed to present the picture of diseases of the thyroid gland in such a way that medically trained readers may emerge with a better understanding of the aims of the surgeon, and surgically trained readers may better understand what the internist and radiologist are able to accomplish."

The chapters on physiology and pathology have avoided the controversial and highly theoretical aspects of the subject. Only practical and generally accepted data are included.

The chapters on treatment are written with a nice sense of balance involving respect for the old and well-established therapeutic principles on one hand, and interest in appraisal of newer principles on the other hand.

Sections on malignancy of the thyroid gland are especially well written and informative.

The text is well illustrated with clinical photographs, illustrations of operative procedures, and tables of clinical information.

SEARCHLIGHTS ON DELINQUENCY. By K. R.

Eissler, M.D., managing editor; Paul Federn, M.D., chairman of the editorial board. This book is dedicated to Professor August Aichhorn, on the occasion of his seventieth birthday. 456 pages. Cloth. Price \$10.00. International Universities Press, New York, N. Y., 1949.

This book will be of value to every psychiatrist who is interested in the psychopathology of delinquency. The book presents a collection of papers written by colleagues and students of Professor August Aichhorn, compiled to honor him on the occasion of his seventieth birthday. (Professor Aichhorn is noted for the application of psychoanalytic principles in the study of delinquency). The papers, psychoanalytic in type, discuss general problems of delinquency, clinical problems, techniques, and therapy, as well as etiology and development. Excellent papers on social psychology and penology are also presented, as is a bibliography of August Aichhorn's writings. The papers which deal with clinical problems and techniques, as well as therapy, are excellent and can be read with profit by any physician who attempts the guidance of the delinquent.

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CURRENT THERAPY 1949—Latest Approved Methods of Treatment for the Practicing Physician: By Howard F. Conn, M.D., Editor. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh H. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 672 pages. Cloth. Price \$10.00. W. B. Saunders Co., Philadelphia and London. 1949.

Current Therapy 1949, a large (8" x 11"), book deals with treatment only: medical treatment and surgical treatment. There is no preliminary note of anything else about the condition discussed, just 1949 current therapy. It is the treatment as used by well known physicians and surgeons and as told by two hundred thirty-six of them. There are no illustrations, but there are many written-out prescriptions and treatment schedules.

Fourteen sections make up this book, and for quick reference the first page of each section has an alphabetical, page-numbered listing of all diseases covered in that section.

There is usually more than one opinion given for the more common disorders. For examples of the variety in the book, Warren H. Cole, Clarence Dennis, and Keith S. Grimm report on appendiceal abscess; J. F. Burgess, Richard L. Sutton, Jr., Bernard H. Winston and Carroll Wright report on lupus erythematosus; and Conrad G. Collins and Wilbur F. Mengert report on pre- and post-operative care in gynecology. The material is presented in easy-to-read outline form, two columns to a page.

There is a twenty-nine page index of subjects and a four page index of author-contributors.

This is the first number of a yearbook of therapy which bids fair to be an exceedingly helpful book for the busy practitioner.

Pierce MacKenzie, M.D.

MEDICAL, DENTAL, AND VETERINARY RESERVE CORPS OFFICERS GET QUESTIONNAIRES

A survey among reserve officers of the Army Medical, Dental, and Veterinary Corps is being taken by means of a questionnaire. The purpose of the survey is to determine the availability of these officers for short periods of duty ranging from one to twenty-nine days a month and for longer duty tours of varying lengths.

The questionnaire is simple in form and requires not more than a few minutes to fill out. Accompanying the questionnaires will be a letter of instruction containing all necessary information. The questionnaires and letters of instruction will be forwarded to the reserve officers by the State Senior Instructors. Return of the completed questionnaire does not in any way pledge or obligate the reservist to a return to active duty.

The response to the questionnaires will determine the possibility of establishing the program and the number of physicians, dentists, and veterinarians who would be available for either the short or longer periods of duty to help relieve the Army's critical shortages of these professional categories occasioned by the imminent separation of approximately 2,000 Medical Department officers trained under the Army Specialized Training Program.

The questionnaire is broken down into four plans, which would permit the reserve officer to enter active duty for periods of one day to three years. In brief, the plans are as follows:

Plan 1. Reserve officers may volunteer for periods of active duty of one or more days a week, to perform professional duties at neighboring Army or Air Force installations. The officer may serve in his present (terminal leave) rank, earn points toward retirement, and carry on his private practice without undue interference. The procedure of issuing orders, certification, and payment will be performed locally in order to avoid administrative delays and to permit the officer to

devote full time to caring for patients. On a simple mathematical basis, under this plan, if 5,000 reserve officers of the more than 21,000 in the country volunteered for only three days a month for a year, the man-hours contributed would be equal to the full-time services of 600 physicians, dentists, and veterinarians.

Plan 2. An officer may enter active duty for periods of from one month to a year. This plan is limited to specialists subject to certain provisions, namely (a) movement of dependents or household goods, or travel by private conveyance are not authorized; (b) officers volunteering for periods of at least six months will be permitted overseas assignments, but dependents may not accompany officer.

Plan 3. An officer may enter active duty from one to three years, and by doing so receive \$100.00 a month in addition to pay and allowances. Assignment, either in this country or abroad, will be made according to military requirements and the professional qualifications of the officer. Dependents and household goods may accompany officers.

Plan 4. An officer may enter active duty for one year at an Army or Air Force installation immediately adjacent to his home. He will not be moved during the year, and may continue as much of his private practice as does not interfere with his military duties. He will receive \$100.00 a month in addition to pay and allowances.

"The Army Medical Department is faced with an unparalleled peace-time emergency in carrying out medical requirements satisfactorily," General Bliss stated. "In time of military emergency, it is the reserve officer upon whom the great burden of effort and sacrifice has fallen. Today, we are again turning to reserve officers of the Medical Department for help."

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OFFICE PROCTOLOGY*

RICHARD H. APPEL, M.D.

INDIANAPOLIS

THERE must be a reason for the frequent recurrence of this subject in medical meetings and magazines. Because of repetition the subject appears trite and hackneyed. Office proctology has been affected less by penicillin and other similar drugs than any other branch of medicine, so there probably has been less change in its procedures than in other fields of medicine. The explanation is simple, in that most rectal symptoms are the result of physiological disturbances of the anal canal, and not of infection. If there is any innovation in therapy, it is chiefly in the increased use of oil soluble anesthetics, which have been used in lesser degree in past years. Thus, the therapeutic agents in proctology are much the same as in years past, with only their refinements in use as a change. The reason then for papers on such a subject must come from pressure from patients for such treatment, or lack of knowledge in this field.

Lately, there has been a breakdown in the prejudice induced by modesty against rectal examinations. I can assure you that both male and female patients with rectal symptoms are beginning to think in terms of a real examination, and not of a suppository prescription. A real examination involves thorough inspection, digital palpation, and use of an anoscope. I know that we have been lax in making a rectal examination, for during the period in which I practiced general medicine I and the men about me either gave such prescriptions or referred the cases to general surgeons. I had never

seen the simple procedures of this field while in school or hospital, except for incision of a thrombotic pile.

The increased tendency to make use of medical services, partially as a result of service experiences, and partially as a result of insurance plans, has resulted in a marked increase in the number of patients who present themselves with symptoms of rectal disturbance. I am astonished at the number of patients who report similar or worse conditions in parents, whose conditions have existed for years. I believe that one of the most important results of an attempt to perform the procedures of office proctology will be the resultant improvement in the diagnostic abilities of the individual making the attempt, and thus the discovery of more serious conditions. He will keep better control of the patient and thus direct him to more radical procedures when such are indicated. The doctor will derive personal satisfaction and pleased patients in most cases so treated.

The recent publicity given to carcinoma, and bleeding as an early symptom of rectal carcinoma, is going to place increasing responsibility on the physician to ascertain the cause of such bleeding.

There is still an unfilled, wide gap between the suppository or surgical type of treatments. In the present, as in the past, this gap has been filled chiefly by the few proctologists, the few interested general practitioners, and the relatively many osteopaths and chiropractors. I can accurately assure the general practitioner that this gap can best be filled by him if he is interested, to the mutual advantage of practitioner and patient.

* Presented at the General Meeting of the Indiana State Medical Association, at the annual session in Indianapolis, October 27, 1948.

The essential equipment for the practice of office proctology consists of an anoscope, a good, bright light, an injection syringe, a 5 cc. syringe, a small gauge needle, a number 18 gauge needle, sclerosing solution, 2 percent novocain in water, 5 percent novocain in organic oil, a silver probe, Allis forceps, thumb forceps, hemostats, finger cots, cotton applicators, and 10 percent novocain in lanolin. His chief technique is gentleness, his goal is diagnosis. Treatment is easy.

Let me suggest here that those who wish to treat patients with rectal symptoms first learn to approach the patient with extreme gentleness. The pain ensuing from a rough rectal examination does much to discourage subsequent ones. Tell the patient first exactly what your next action will be. First examine the perianal skin not only for tumors and fistulous openings, but also for laxness of the skin, which may represent some degree of prolapse or distention during bowel movement. By pulling down gently on this skin, it may be possible to expose and learn of fissures, which usually are situated in the lower canal.

Next attempt a digital examination, inserting the well lubricated finger very slowly. If an area of extreme tenderness is encountered, stop and attempt to anesthetize the area, either with a 10 percent novocain preparation, or slowly inject a novocain solution beneath the involved tissue. If the novocain solution is followed with an oil soluble anesthetic, anesthesia will persist for three to four days, which in itself is good treatment in many types of acute fissures.

As in all other branches of medicine, correct diagnosis is the most certain path to correct treatment. I am going to try to use a somewhat different approach to the causes of rectal symptoms than the usual, in an attempt to simplify the explanation of such causes. The usual approach to such an explanation is through the use of classification, such as cryptitis, papillitis, internal hemorrhoids, external hemorrhoids, and proctitis. Let us instead consider the anal canal and adjacent mucous membrane and anal skin as a physiological entity, and call it the outlet. Practically, the outlet functions as an entity regardless of the types of tissue concerned. The various muscles of the outlet act in unity, and not separately. Only the anatomists and proctologists have attempted to subdivide its functions. Nature did not.

Relaxation of the canal must precede stool passage, in order to achieve the eversion of the canal tissues which occurs with complete evacuation. If irritation exists in a marked degree, such as is seen in abscesses and acute fissures, such relaxation is not obtained. Also if irritation of sufficient degree develops with inauguration of the act of defecation, the muscles will clamp down and interfere with completion of the act. This happens frequently with prolapsing hemorrhoids.

The symptoms which bring a patient to the office are the result of a dysfunction of the outlet.

Any pathology of the outlet will result in muscle tension or muscle pain, and thus increases pressure against the outlet with stool passage. This in turn may produce new lesions. A fissure may cause bleeding from internal hemorrhoids above, as a result of this increased pressure. Or an irritation of the lower mucous membrane of the internal hemorrhoids may result in fissure formation in the skin below the canal. Both cause sphincter spasm, so one lesion operates through this mechanism of spasm to create other lesions. Mild irritation of the tissues of the canal from dilated vessels or fissures can give rise to a very disturbing pruritus which can spread to the vulva or on the scrotum. From this disturbance of anal function ensue such symptoms as constipation, abdominal distention, backache, legache, difficult evacuation, and bladder dysfunction. This necessitates that a good history be taken to try to discover if anal function has been disturbed.

The factors which lead to such dysfunction can be found in mild or marked changes in the tissues of the outlet, plus the often perplexing factor of marked sensitivity to such changes. Some of these variations from the normal are easily seen or felt, but some are not. The tension of the sphincters can do much to hide the milder changes by supporting the tissues of this area. Let me caution the examiner against accrediting the inserted finger with too much diagnostic acumen. The value of palpation is in acquiring information as to the tender areas, muscle tension, scar formation, benign and malignant tumors and impactions. The value of the scope is in acquiring information of ulcers, congestion, fissures, irritation of the mucosa, presence of blood and type of blood, prolapse, and dilatation of tissues of the canal. I have treated and operated cases which gave no evidence of pathology on examination, with entirely satisfactory results, on the basis of history and reaction to a diagnostic injection of a sclerosing solution into the internal hemorrhoids.

For simplification, we will use the term irritation to include all alterations of outlet tissues which result in symptoms of outlet dysfunction. Thus irritation results from any abrasion of these tissues, or any tension exerted upon them or by them. In the first group are ulcers, fissures, sinus openings, and mild rubbing of lower mucosa, such as occurs during bowel movement and walking. Tension results from tissue which has been stretched by prolapse, slight distention of any of the subcutaneous vessels, benign or malignant growths.

As mentioned before, the reaction to such irritation varies with the unknown factor X of the personality and anal sensitivity of the individual. One person with extreme prolapse complains only of the embarrassment of protruding tissue which must be frequently reduced, while another is in agony from mild swelling of the tissues of the canal. I saw two patients in one day, each with an

ulcer which corresponded in size and location with the other. One complained of pain and bleeding, but with no backache. The other had no rectal discomfort or bleeding, but had such severe backache and sciatic pain that he limped while using a cane.

The term irritation which we selected to describe these changes was chosen advisedly, for these changes irritate the smooth muscle fibers of the sphincters, which are the source of most rectal pain. Stimulated, they contract and give rise to pain which varies from sharp, stabbing pain to mild discomfort.

One patient retires at night, relaxes for sleep, and the sphincters relax to permit mild congestion or prolapse, thus diminishment of muscle support of tissues. As a result irritation develops and mild, unfelt spasm results in ensuing pruritus. He digs at the tissues in his sleep, and the symptoms grow worse from the irritation of his scratching. The next day he is under tension from business pressures, tightens his anal musculature, and thus creates additional congestion and irritation.

Another patient does likewise in regard to retiring and relaxation, to awaken at midnight with excruciating pain from extreme spasm of the sphincters. One patient with a fissure has a bowel movement and suffers knife-like pain, while another with a similar condition develops a dull ache of the anal canal.

We are prepared to proceed to the actual office treatment of rectal disturbances and so we will consider first the therapeutic weapons available. This list includes suppositories, soothing or analgesic ointments, topical applications, oil retention enemas, injection of internal hemorrhoids, injection of an oil soluble anesthetic, preparations similar to metamucil, mineral oil, and dilatation.

The purpose then in treatment is to eliminate the irritative lesions, or at least their effect on the sphincters. Thus it is possible to lessen the bruising of the canal or the irritation of ulcers by using mineral oil or metamucil. It is possible to soothe the abrasion or mild irritations of the mucocutaneous line level with suppositories or oil retention. Obviously this is the least effective of therapeutic measures.

Injection of the internal hemorrhoids may reduce swelling of these hemorrhoids to such a degree that symptoms subside. This lessens spasm, bleeding and pain, and since this swelling of internal hemorrhoids is one of the most frequent causes of distress, such treatment is widely used. Since none of the lesions of the canal or external tissue cannot be shrunk by such treatment, and since dilatation of the canal is one of the frequent causes of dysfunction, injection of internal hemorrhoids is not comprehensive treatment. It is obvious that usually when there is dilatation of the internal hemorrhoids, the prolapsing influence extends to

the vessels of the canal. Sometimes a shrinkage of the internals will serve to pull the skin of the canal upwards and reduce tension.

Topical applications, such as salves and silver nitrate, obviously are not nearly as effective in silencing irritation of acute congestion of canal vessels and fissures as persisting anesthesia of the subcutaneous tissues, achieved with oil soluble anesthetics. This relieves the muscle spasm, decreases muscle tension and stool bruising, and gives the abraded surface a chance to heal.

Let me interject here the statement that clinically I have never seen any ill effect from the occasional or daily intake of mineral oil. None can be seen on the wall of the bowel, and the evening dose of mineral oil is not likely to mix with any of the food intake until admixture in the large bowel, after absorption of vitamins has probably been completed. I try to avoid its use, but am not afraid of such use.

Because injection of sclerosing solutions is the most effective agent of the beginner, and the one of chief value in office practice, it is best to consider it in greater detail. Theoretically and actually surgery of outlet disturbances is by far the best of all therapeutic agents, but practical considerations of cost and convalescence limit its applicability to those cases in which ambulatory treatment is not practicable.

As stated before, the frequent use of injections would induce practitioners to look up into the lower pouch and see suspicious mucus, blood, bloody mucus, benign and malignant tumors. The use of injections can be learned in a very few lessons.

The first point to remember in the use of injections is to make the injections at a level at least an inch above the mucocutaneous line. Since the fluid tends to disseminate, it will spread to lower levels. If injections are made close to the mucocutaneous level, marked discomfort is likely to follow such an injection. Three to five injections should be distributed about the circumference of the bowel wall, and about one cc. of solution should be injected at each side. This can be repeated at five to ten day intervals. Three to five such injections are sufficient to demonstrate their efficacy in any given case. After this preliminary short course, they can be given occasional injections for recurring symptoms. A protracted course with suggestion of permanent cure is quackery.

The use of injections is deplored chiefly by those who have never tried them intelligently. Used with ordinary precautions, they constitute a very safe procedure. The vessels of the involved tissue are scarcely any larger in diameter than those of other areas of the body, where injections are frequent, and the needle used is much larger. The reaction to the injections is perivascular and not intravascular. Surprisingly enough, the results

are particularly effective in cases in which there are symptoms of fullness and mild discomfort of the rectal pouch, without any evidence of distention of internal hemorrhoids.

I believe that a practitioner without a sigmoidoscope will find injections of marked value in cases of rectal bleeding. Injections are surprisingly helpful in determining whether the source is that of the internal hemorrhoids or other pathology. Any case which does not show cessation of bleeding with two or three thorough injections will likely reveal other pathology, such as benign or malignant tumors, or disease processes of the bowel. Use of injections in cases of rectal bleeding can help much in the early diagnosis of carcinomas.

I am not endorsing the use of injections as the choice of treatment in rectal diseases. There is no reason for arguments as to preference. I try usually to prescribe surgery, but have found the injection method invaluable in diagnosis, and for relief of symptoms in those rejecting surgery, and in a limited, selected group as the therapy of choice. Again, this does not produce the satisfactory results of surgery, but on the other hand is far superior to the more frequent treatment of salves and ointments. It is into this field of office treatment that the quacks and charlatans slip, with their guarantee of cures, high fees, and neglect of serious cases. Their results in the eligible cases are so much better than those of suppository treatments that their practices grow amazingly.

Let me add a remark here on the so-called electric needle, or cautery treatment. I consider it the poorest, most painful, and the most ineffective of any form of therapy. I have been told by many patients that it is more painful than a complete hemorrhoidectomy. Certainly it is neither more effective nor safer than injections, and is not a substitute for injections or surgery.

The next therapeutic weapon to consider is that of novocain and other similar analgesics, in water and in oil solutions. If there has been any advance in recent years in office treatment of rectal disturbances, it has been in the wider application of the use of oil soluble anesthetics.

Particularly in the treatment of acute fissures, one of the most distressing of rectal conditions, its results are superb. Careful, slow, preliminary injection of a 1 or 2 percent water solution of novocain can be accomplished with little or no discomfort to the patient. This permits a more careful examination of the lesion, a better examination of the canal and the lower rectal pouch above. Thus other pathology can be ruled out. If the patient's symptoms subside, after such use of a water soluble novocain solution, then one or two ccs. of a 5 percent oil soluble injection can readily be placed beneath the fissure. This will relieve the pain for three to four days, will decrease

the trauma of stool passage, and will speed the process of healing.

It is also extremely valuable in the treatment of external thrombotics. Let me urge all of you who incise external thrombotics to try the following procedure. Instead of simple incision of external thrombotics, anesthetize the area involved, which includes the skin adjacent to the clot, excise the tissues widely, then inject beneath the denuded area with 2 to 3 cc. of oil soluble anesthetic. There should be no real discomfort following incision, no tendency to a reforming of the clot from additional hemorrhage, and no tendency to the later recurrences of the condition. Oftentimes the patient will be relieved of minor symptoms resulting from the loose tissue so excised.

A careful injection of oil soluble anesthetic can also be used to anesthetize the sphincters in cases of impaction. Since there is usually a bruising of the upper canal from the attempts at defecation, and frequently there is some fissuring, this procedure will serve the double purpose of easing the pain of the impaction removal, and will also abate the pain which is usual, subsequent to such removal.

As proficiency in use of this agent improves, and judgment and confidence grow, other applications are found to be indicated. Single, prolapsed hemorrhoids, particularly in late pregnancy, can be anesthetized with oil soluble novocain, when excision does not seem to be justified. Certain types of single prolapsing hemorrhoids, in short canals, can be excised with no discomfort to the patient, by following excision with injection of oil soluble anesthesia beneath the denuded surface. It is possible to excise superficial fistulas, rectal polyps, et cetera.

Peculiarly enough, I tend less and less to open perirectal abscesses in the office. I treat only those which are superficial, and ready to drain, in the office. Ischiorectal abscess should be incised early, and should be given good drainage. To do this usually requires a wide and deep incision, and this can never be done well under local anesthetics. That is the most effective method of preventing tissue damage, scar and granulation tissue formation, and a tendency to result in recurrent abscesses and fistulas.

The treatment of pruritus is a subject of itself, so I will not take up much time with this condition. I am personally convinced that all pruritus results from outlet irritation of a mild degree, with an individual tendency to react with pruritus. Careful questioning of the patient will reveal that it is more of a deep tissue discomfort than a superficial itching. I believe that mild congestion of the sensitive areas of the lower mucosa, canal, and perirectal skin results in mild stimulation of the nerve terminals, and causes pruritus in susceptible individuals. It creates a vicious cycle, in that the

sensation leads to finger digging while asleep or awake, and thus increases the congestion of the invoked tissues. That certain people are extremely sensitive to such nerve irritation is demonstrated by the fact that they may follow their anal pruritus with tingling of areas as distant as the hands, and even with neurodermitis of the face, body and extremities. In other words, pruritus is the mildest form of rectal pain. The only office procedure I have found to be of value in treatment of this condition is the use of injection of internal hemorrhoids, and a water solution with a high percentage of phenol. Either may interrupt the cycle temporarily, and result in improvement. Salves and x-ray are either nonbeneficial or exaggerate the condition. Surgery in chronic cases

of pruritus is by far the most effective treatment, but the simpler forms of treatment should be used first.

If the physician will keep in mind the fact that chronic rectal conditions are often as irritating as chronic headaches, as crippling as chronic backaches, and as tiring as chronic foot trouble, all combined, he will be led to use the simple procedures mentioned above, and develop and extend his efforts in the treatment of such disturbances. It is unfortunate that no local clinics exist to demonstrate such methods, but a demand on his part could easily lead to their creation. Too, he should recognize that hospital surgery of the intractable cases is not the horrible ordeal it once was.

MANAGEMENT OF BREECH PRESENTATION*

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FOR the physician who includes obstetrics in his or her practice, the two positions which most frequently give considerable trouble are the persistent occiput posterior and breech presentations. The former was discussed by the author at the meeting of the American Medical Association in June, 1948. The present paper is based on those breech presentations encountered during the years 1942-1947, the same time interval used for the occiput posterior report. I will consider single pregnancies presenting by the breech at or near term, as they constitute most of the mechanical difficulty encountered with this presentation. However, much of the fetal mortality encountered in breech presentation is found in prematurity, especially when combined with multiple pregnancy. The increased incidence of monsters and gross deformities occurring with breech is also noteworthy.

Breech presentations occurring during this time interval in the practice of the author, but excluded from this study, are as follows:

1. At the Methodist Hospital there was one premature with breech presentation and multiple deformities, the baby dying after one hour. Also, there were seven sets of twins. Of the latter, five sets of twins presented, with the first baby cephalic

and the second breech. Of these, one set of twins at seven months' gestation died, as did one set at eight months. In one set of twins both babies presented by the breech, while in one set the first baby presented by the brow and the other by the breech.

2. At the Coleman Hospital there was one set of twins, the first baby being cephalic and the second breech. There also was one anencephalic monster that died in utero.

3. At St. Vincent's Hospital there was one baby near term, with multiple deformities, that died in forty-eight hours; one premature (7 months), the mother having had a pelvic fracture following an automobile accident. This baby died on the fourth day from intracranial hemorrhage. There was also one set of twins at this hospital, the first having a breech presentation and the second a shoulder presentation. The breech baby died of a congenital heart.

Incidence. In a recent report Meyer¹ of New Orleans, including in his study single pregnancies only, seven months or more, gives an incidence of 3.1 percent of breech presentation in 13,577 deliveries occurring in the Tourro Infirmary. In 14,000 cases at the Chicago Maternity Center the incidence was 3.24 percent, and at Chicago Lying-in 4.2 percent in 35,000 cases.² In the 2,922 cases delivered by the author in the years 1942-1947

* Presented at the General Meeting of the Indiana State Medical Association, at the annual session in Indianapolis, October 28, 1948.

inclusive, there were 109 breech presentations at or near term, an incidence of 3.73 percent, as shown in Table I.

TABLE I
INCIDENCE

Year	Total Deliveries	Breech Presentations At or Near Term
1942	415	14
1943	442	13
1944	428	13
1945	537	21
1946	553	26
1947	547	22
TOTAL	2922	109

INCIDENCE 3.73%

Of the 109 cases of single breech at or near term, there were 93 vaginal deliveries and 16 cesarean sections, this giving a percentage of 85.3 delivered vaginally and 14.6 delivered by cesarean section. Tompkins³ reported 211 cases of breech being handled by 17 obstetricians with a cesarean incidence of 14.2 percent.

Parity. All 16 cases delivered by cesarean section were primiparae, as were 64 of the 93 cases delivered vaginally, as shown in Table II.

TABLE II

Parity of the 93 Single Pregnancies with Breech Presentation At or Near Term Delivered Vaginally

	Hospital				Total
	Meth- odist	Cole- man	St. Vincent's	City	
Para I	18	27	18	1	64
Para II	7	13	2	0	22
Para III	2	0	3	0	5
Para IV	1	0	0	0	1
Para IX	0	0	1	0	1

Etiology. Most textbooks list prematurity, placenta praevia, hydrocephalus, multiparity, multiple pregnancy, contracted pelvis and pelvic tumors as classical causes, but Tompkins⁴ has recently shown that only about one-sixth of cases of breech presentation can be accounted for by the above factors.

Breech presentation is very frequent up until the twenty-fourth to thirty-sixth week of pregnancy, when spontaneous version usually occurs. If the patient goes into premature labor before the thirty-fourth week, she is very apt to have a breech presentation. Vartan⁵ states that one patient in four has a breech at some time during pregnancy and that spontaneous version occurs in three out of five cases.

One of the most important causes of persistent breech seems to be extension of the legs, rendering spontaneous as well as external version much more

difficult and unlikely. The poorly developed uterus, such as the uterus arcuatus, is particularly apt to house a baby with breech presentation.

MANAGEMENT DURING PREGNANCY

It seems wise to examine frequently the abdomen of the prenatal patient after seven months to recognize breech presentation and, if possible, to correct it. The classic maneuvers of abdominal examination will find the ovoid longitudinal, the breech over the inlet and the head in the fundus. When this occurs, it is advisable by very gentle means to attempt external version. The lower pole of the baby may be gently pushed upwards with the hand above the symphysis and an attempt made to reverse the polarity of the baby. Often this will be a very easy procedure. At other times, it will be impossible and most authorities believe that external version should not be attempted under general anesthesia. Fetal heart tones should be watched constantly. Ryder⁶ points out that failure in external version is due either to extension of the legs or to delaying attempts until too late in pregnancy. Turning during the procedure should be done so that flexion of the baby's body occurs simultaneously. However, if failure should occur, the opposite direction may be tried. The low incidence of complications of the maneuver is more than offset by the increased safety to the baby delivered as a vertex. A roentgenogram of the abdomen before attempt at external version is not only helpful, but also an additional safeguard. In case of marked extension of the head, such as recently reported by Taylor,⁷ the condition will be revealed by x-ray, and, with this condition present, attempts at external version might produce dislocation of cervical vertebrae or even injury to the cord. Labor itself might cause the same thing and in this rare situation Taylor reports Titus' endorsement of elective cesarean section.

It is also of utmost importance to measure the pelvis accurately prenatally. In every primigravida that has a breech presentation, x-ray pelvimetry should be done. Any of several methods may be used, one of the simplest and best being that of Thoms. As recently shown by Mengert⁸ the anterior posterior and transverse diameters of the inlet and mid-pelvis are essential. He states that the product of the two diameters of each plane is as satisfactory a measure of relative capacity as the more laboriously obtained measurement of the actual area. Mengert has established a normal of 145 for the inlet and 125 for the mid-plane. Eighty-five percent of normal capacity of either plane represents the borderline between adequacy and contraction. He is doubtful as to whether outlet contraction exists as a separate entity unassociated with mid-plane contraction. Much of what in the past we have termed outlet contraction actually is mid-plane contraction at the level of the ischial spines.

Estimation of the size and capacity of the fetal head is also important, particularly as diameters of the head are not changed during labor due to the absence of molding in the aftercoming head.

MANAGEMENT OF LABOR IN BREECH PRESENTATION

First Stage: Because the breech does not fit the inlet of the pelvis as accurately as the head, that part of the bag of waters below the presenting part is subjected to the total intra-uterine pressure and the membranes may rupture before labor or just at the onset of labor. If this happens, there is always the possibility of prolapse of the cord so that the patient with ruptured membranes should be in bed. Fetal heart tones should be carefully checked.

Often the presenting part will stay high throughout the first stage and it may be difficult to tell the amount of cervical dilatation by rectal examination. When the patient is suffering, some type of analgesia should be given. At full term, we have employed nembutal plus rectal ether, and, more recently, have used more demerol with scopolamine. It is of greatest importance that, if the baby be premature, a minimum amount of analgesia be given, and, if possible, none.

If progress of labor is slow, dehydration is combatted by intravenous dextrose and it is wise again to evaluate the size of the pelvis and the size of the baby. A trial of labor does not mean much with breech presentation except as a measure of the forces of labor. The decision as to whether the patient should be delivered by cesarean section should be made either before the onset of labor or shortly afterwards. The size of the baby, size of the pelvis, and the age of the patient, if she is a primigravida, will help materially in this decision.

Second Stage and Delivery: We prefer to have the patient with breech presentation awake when she goes to the delivery room so that we may have full benefit of her bearing down efforts.

It is of greatest importance that the baby be not extracted until the cervix is completely dilated and out of the way, as a cuff of cervix may prevent delivery of the aftercoming head, or so increase the time required for delivery as to jeopardize the baby.

While Irving and Goethels⁹ long have advocated breech extraction as soon as full dilatation of the cervix is reached, we prefer to give the mother a chance to push the breech out spontaneously, and often allow her two hours in the second stage, especially in cases of so-called frank breech or incomplete breech. She may have intermittent gas or ether while this trial is being made. If the patient can deliver the buttocks herself, then she is quickly anesthetized for the remainder of the delivery, which is usually the so-called manual aid or breech extraction minus the first act.

First Act of Breech Extraction: For extraction, we prefer that the patient be asleep and that the bladder be empty. Unless the perineum is markedly relaxed, we do a deep mediolateral episiotomy before starting extraction. In complete breech when both feet are accessible, there will be no difficulty in bringing down the feet. In incomplete breech or frank breech, one may have to go to the top of the fundus to secure the feet, which can be brought down directly or by using the Pinard maneuver. If only one foot can be obtained, it is better to get the anterior one, as this tends to rotate the back anteriorly.

Second Act: As soon as the feet and buttocks are delivered, by combined traction from below and pressure from above, the body up to the shoulders can usually be delivered without difficulty.

Third Act: Delivery of the shoulders may be comparatively easy or may be with great difficulty. If there is a nuchal hitch, this must be diagnosed and the arm brought over the face. Fractures of long bones may be minimized by exerting pressure only over the flexor surface at an articulation. In this series, there were three cases of fracture of the humerus all associated with releasing a nuchal hitch.

If the arms can be maintained across the chest, complications with the arms will not arise. Potter¹⁰ considers primary breech presentation to be a much more formidable condition than breech after version, because in the latter the arms can be controlled. The Potter technique of delivery of the shoulders and arms in breech has been a great contribution. This consists in delivery of the scapula of the anterior shoulder and then pressure in the axilla towards the vertebral column, bringing the arms directly down as one would lower a pump handle. The posterior arm can be delivered as such or the baby rotated to make it anterior and then delivered like the first.

Fourth Act: Delivery of the aftercoming head may give great difficulty. Because of this, the doctor should always have sterile forceps ready before starting any breech delivery. One never knows beforehand when they may be necessary and the lack of them may cause loss of the baby. The ordinary Simpson forceps or the DeLee Modified Simpson will do very well, but the best forceps for the aftercoming head is the Piper forceps, especially designed and constructed for that purpose.

Often the head will deliver with the simple Weigand-Martin maneuver, with the baby's body straddling the arms of the operator, the latter's two fingers being in the baby's mouth at the angles of the jaw, to maintain flexion, and the operator's other hand using gentle pressure above the symphysis. If it does not come easily, forceps should be applied.

Abnormal Rotation of the Head. Occasionally, in spite of all efforts to prevent it, the occiput of the aftercoming head will rotate posteriorly and the mouth of the baby be inaccessible above the symphysis. Unless one is able to rotate the head easily, it is much better to apply the Piper forceps with the occiput toward the perineum and the face anteriorly. This was done in two instances in this series and the babies were saved. In a similar instance twenty years ago, I lost a baby by wasting valuable time in attempting to rotate the head. Piper forceps applied to the abnormally rotated aftercoming head is also much preferable to the so-called Prague maneuver.

The management of our cases is given in Table III, while Table IV gives the indications for cesarean section in that group delivered abdominally.

TABLE III

Management of Our Cases of Single Pregnancies with Breech Presentation at or near Term

	Hospital				Total
	St. Vincent's	Coleman	Meth-odist	City	
Manual Aid	10	11	12	0	33
Manual Aid with Forceps to A. C. Head	5	8	6	0	19
Breech Extrac-tion	4	5	5	1	15
Breech Extrac-tion with Forceps to A. C. Head	5	16*	5	0	26
Cesarean Sec-tion	5	7	4	0	16

* Abnormal Rotation in 2.

85.3% Delivered Vaginally

TABLE IV
Indication for Cesarean Section

Borderline pelvis with contracted outlet and large baby	3
Elderly primigravidae; 1 age 36; 2 age 38	3
Breech with large baby and failure of labor	8
Flat pelvis with large baby	1
Pre-eclampsia	1
(5 cases were consultation cases)	

TABLE V

Types of Cesarean Section

			Total
	Transverse	Longitudinal	
Low Cervical	13	2	15
Low Classic			1

RESULTS

Maternal. None of the 109 mothers died. There was no morbidity, according to the standard of the American College of Surgeons, for the vaginal cases, and for the cesarean sections 18.7 percent.

In two instances the episiotomy extended through the sphincter muscle.

Fetal. There was one neonatal death, the baby dying after forty-eight hours of intracranial hemorrhage. This gives a fetal mortality of .9 of 1 percent for babies at or near term. In the case of this fetal death, the baby entered the pelvis with the occiput down. Rotation was done and the head delivered by the Weigand-Martin maneuver.

There were also three babies who had fractures of the humerus, all with nuchal hitch, and another baby suffered an oblique fracture of the clavicle. There were no brain injuries. Sex and weight range of all babies are given in Tables VI to IX.

TABLE VI
Sex of Babies Delivered Vaginally

	Hospital				Total
	Meth-odist	Cole-man	St. Vincent's	City	
Girls	14	26	14	0	54
Boys	14	14	10	1	39

TABLE VII
Sex of Babies Delivered by Cesarean Section

	Hospital				Total
	Meth-odist	Cole-man	St. Vincent's	City	
Girls	2	2	1	0	5
Boys	2	5	4	0	11

TABLE VIII
Weights of Babies Delivered Vaginally

Lbs.	Hospital				Total
	Meth-odist	Cole-man	St. Vincent's	City	
4-5	0	1	0	0	1
5-6	6	2	3	0	11
6-7	9	17	7	0	33
7-8	7	11	10	0	28
8-9	6	9	4	1	20

TABLE IX
Weights of Babies Delivered by Cesarean Section

Lbs.	Hospital				Total
	Meth-odist	Cole-man	St. Vincent's	City	
6-7	0	0	1	0	1
7-8	1	2	2	0	5
8-9	2	3	2	0	7
9-10	0	1	0	0	1
10-11	1	1	0	0	2

The additional fetal loss, consisting of pre-matures, twins and monsters, with breech presentation occurring during this period has been previously enumerated. Dieckman¹¹ has stated that breech presentation and delivery has a gross fetal mortality of 7.7, corrected to 4.2 percent for full

term fetuses, and that mortality among prematures is over 25 percent. Certainly the mortality of term fetuses can be kept to 1 or 2 percent, but salvage of many of the premature babies can only be increased by the prevention of premature labor and by better care of the premature baby.

SUMMARY AND CONCLUSIONS

1. There were 109 breech presentations in single pregnancies at or near term occurring in a total of 2,922 deliveries, an incidence of 3.73 percent. The incidence of persistent occiput posterior in the same group of cases was 3.6 percent.
2. Repeated abdominal examinations are urged after seven months of pregnancy in order that the breech case may be diagnosed early and, if possible, external version done.
3. Accurate evaluation of the pelvis and the size of the baby are essential in deciding for or against cesarean section. In elderly primigravidae, the decision will be much easier.
4. Much of the fetal loss in breech presentation is due to prematurity and congenital deformities. With proper management, fetal survival at or near term can be held to a lower figure than that given in most obstetric texts.

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COMMON OFFICE PROBLEMS IN GYNECOLOGY*

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GARY

OFFICE problems in gynecology are numerous. For the sake of brevity, I have chosen a few most common conditions which task our vast therapeutic armamentarium.

Introduction of these problems will be rather unorthodox. Symptoms, rather than diagnosis, will be used, as symptoms may preclude several diagnoses in the same individual.

Furthermore, I firmly believe that we should treat the patient, not just Mrs. Dysmenorrhea or Mrs. Trichomonas Vaginitis.

In a recent *Journal of the Indiana State Medical Association*, Dr. Gatch¹ has made this statement: "Despite all progress we have made in the prevention and treatment of disease, the care of the sick remains, and will always remain, more of an art than a science." Pink tablets are sometimes more effective than white. I believe we all have had such experience.

My first discussion is presenting, so to speak, a woman patient who comes into the office, complaining of itching or burning around the privates. A careful history is obtained. You may or may not do a complete physical examination, including

blood serology and routine urine. If you don't, you had better do it, or you'll miss a case of syphilis, diabetes mellitus, cancer, or other pathological conditions which human females harbor. At last your nurse has the patient ready for a pelvic examination. Under a good light the external genitalia are noted to be reddened and swollen. Perineal and anal regions, likewise, show evidence of irritation such as excoriation and scratching. A digital examination is now made. Skene's glands may be inflamed and show evidence of pus when stripped. A Bartholin gland infection or a benign cyst may be present; urethra may be reddened and tender; a caruncle may be evident. Bimanual examination may be negative, or there may be retroversion or retroflexion of the uterus. Uterus may or may not be enlarged, symmetric and tender, or small, asymmetric and not tender, freely or not freely movable. An entirely different finding may be present. Adnexa may or may not be tender, normal or enlarged. The cervix may "feel" soft, warm, smooth or irregular. Vaginal vault may or may not feel rough. How about the odor of the secretion? Is it foul, mousy, or the ordinary routine acid type?

A speculum examination will now reveal, with a good light, the character of the vaginal mucosa and cervix and color of the discharge in and around

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the cervix. Is the cervix smooth and free from pathology or does it contain small, nabothian cysts, ulceration, erosion or eversion, tears, growths on or in the cervix? Is it inflamed generally or does it show reddened patches which may or may not bleed easily? A drop of secretion is obtained and placed on a hanging drop slide to be examined for trichomonas vaginalis or yeast. The vaginal vault is now swabbed dry. Is it inflamed generally or is it strawberry in distribution? Does it have white, cheesy flakes?

Now we are ready to help this individual, not only for her complaints, but other pathological conditions she was unaware of, and which may be accessory to the original complaint.

Pruritis vulvae then is a condition of itching or smarting more or less in some part of the external genitalia. The source, as you know, is manifold. But for the sake of brevity, a few of the common, everyday factors will be mentioned—moisture, tight clothing, diabetes mellitus, trichomonas vaginalis, yeast, foreign bodies, including pessaries, cervicitis, endocervicitis, vitamin deficiency, allergic sensitivity. Vitamin deficiency may be traced to nutritional inadequacies, alcoholism and infectious diseases. Allergic dermatitis is often traced to soaps, ointments, douches, and rayon clothing. Itching may be due to atrophic vulvitis. Lastly, but not least, is cancer. According to Curtis,² "a watery discharge is an earlier sign of cancer than hemorrhage."

As a rule, complaints of itching or burning, and frequently soreness, are worse during locomotion; more frequent during warm weather. Itching may be so severe that the patient scratches and digs, adding more insult to the already damaged tissue. The skin may become thickened, excoriated, weeping, fissured or pustular.

Not only is the physical condition involved, but the mental attitude of the afflicted female is apparent. Nervousness, restlessness, lack of proper sleep, along with incessant physical discomfort, brings the patient, often in tears, to seek relief.

Treatment is directed to be specific, if possible, as well as symptomatic. The first important step in treating is to teach the patient cleanliness. To control itching or burning, particularly during the night, an ointment containing cocaine derivative should be used. Mild sedatives such as barbiturates are of value for rest. Itching or burning will subside. The irritated skin will have a better chance to improve. Additional treatment depends on what causes the irritation. Fungi respond to salicylic and benzoic acid in an ointment base when rubbed on parts. Silver nitrate, 5 to 10 percent, is of benefit to excoriated, fissured skin.

Vulvar itching due to simple atrophic vulvitis and vaginitis will respond to estrogenic therapy, according to Della Drips, given orally in conjunction with phenobarbital. General supportive treatment, including thiamine and riboflavin, is indicated along with hormonal therapy.

Trichomonas vaginalis vaginitis is the most common form of vaginal discharge which causes pruritis vulvae. According to Curtis,² trichomonas infection is rarely found prior to puberty. After puberty, a profuse, irritating, offensive, creamy or greyish, and somewhat bubbly vaginal discharge, which recurs and persists for a long time, is probably due to trichomonas vaginitis or yeast infection.

All foci of infection in the genital tract must be eradicated to insure a cure. Infections in the cervix, erosions, endocervicitis, should be cauterized or electrocoagulation of the cervix done, or this may be substituted by Sturmdorf's operation after childbearing age.

Local applications for trichomonas vaginitis are numerous. The literature is full of therapy which shows that any one particular treatment may be inadequate. All known antiseptics have been tried. Sulfonamides and penicillin have been tried. According to Abel and Farmer, penicillin has no effect on trichomonas vaginalis, but does affect other organisms, more or less when used topically. It has been found that mercuric chloride, 1:4000 or 1:5000 strength, gives best results in trichomonas and yeast infections. However, this treatment is not without danger, as the mercury may be absorbed and also taken internally accidentally. The "time honored" gentian violet, 1 percent in aqueous solution, kills trichomonas in thirty seconds, according to Curtis.² Though this is somewhat messy, it is much safer to use.

It is agreed by all investigators that cleansing and drying the vaginal vault is an important step in the treatment. Cleansing is done with tincture of green soap. Many investigators use white vinegar, 4 to 10 tablespoonsful, for douching. Karnaky³ has stated that there is a definite relationship of vaginal flora to the pH and glycogen in the vaginal secretion. It was observed that pH below 5.0 trichomonads in mixed bacterial flora died. There are many good proprietary tablets and vaginal suppositories used in conjunction for patients to insert high up in the vagina.

Reich⁴ and others combine argyrol (pulverized), 20 percent by weight, kaolin 40 percent, beta-lactose 40 percent, as insufflation powder, and a No. 12 gelatin capsule containing 4 grams of the powder inserted in the vagina after nightly douching with vinegar and water. The patients were instructed on absolute cleanliness. All foci of infection must be eradicated, either medically by the use of sulfa jellies or suppositories, or by adequate surgical therapy instituted for the individual patient.

Again, vitamin deficiencies play an important part in gynecology. Parks and Martin⁵ state that probably the most common deficiency is the B factors which influence the skin of the vulva. Lack of riboflavin favors mycotic infections. Vitamin A deficiency is associated with development of chronic dermatitis of the vulva, kraurosis and leukoplakia.

Following is a case presentation which turned out to be cancer of the cervix instead of vaginitis. This patient, Mrs. E. B., age 49, complained of frequency of urination, itching and smarting after micturition, three weeks duration. Her menopause was at the age of 42. She was seen May 18, 1946. Positive findings are as follows: B. P. 150/100; the vulva was slightly reddened and swollen; color of vaginal secretion greyish, having a mousy, pungent odor; cervix showed a small area on posterior lip which appeared vascular and slightly eroded, and which bled easily when swabbed with cotton applicator. Bimanual examination showed firmness in the cervix, tender to touch and motion, bladder and urethra tender. Sulfa jelly was placed in vagina and against cervix daily until patient was admitted to hospital five days later, when a biopsy of the cervix was done. Biopsy showed this to be squamous cell carcinoma consisting of cell nests, epithelial pearls, linear growths into hemorrhagic, secondarily infected and ulcerated, underlying smooth muscle. She had an uneventful recovery following radium and x-ray therapy.

Another female patient comes to the office complaining of too much menstruation, and that she had been passing a lot of blood clots, and soaking one pad after another. You detect from her conversation that she is nervous and that she wants to tell everything at one time. Each complaint is followed by another complaint. If you are not too busy and are a good listener, this patient will unravel a very enlightening history with very little prodding and interruption. She may state that in addition to the bleeding she has a lot of cramps, that she cries on the least provocation, that she has headaches, that she feels bloated before onset of menses and gets tired, dizzy and worn out easily. She does not feel hot but she gets chilly. She concludes that she just can't lose weight and doesn't eat a thing!

Vaginal bleeding is due to many conditions. Functional uterine bleeding at the menarche and at premenopause is due to endocrine imbalance. Bleeding during childbearing age may likewise be "functional" but more likely it is due to products of conception—a partial or complete retention of placenta, placenta previa, premature separation of placenta, subinvolution; other conditions, such as submucous fibroids, endometrial and cervical polyps, malignant tumors of the cervix and body of uterus.

Functional bleeding during childbearing period calls for careful history and physical examination. Dilatation and curettage and B. M. R. are indicated. According to Davis,⁶ functional bleeding is due to absence of ovulation and corpus luteum formation, in which case progesterone should correct imbalance and stop bleeding. On the other hand, Loeser⁷ in a survey shows that testosterone, 25 mg., and progesterone, 10 mg., on five consecutive days, give good results, testosterone having hemostatic properties, while progesterone induces desquamation of hyperplastic endometrium. These cases of hyperestrinemia may be induced by too

much estrogen during the course of treatment or possibly to hepatic dysfunction, as pointed out by Glass⁸ and Gordon,⁹ in which case nutritional deficiency, though moderate, will impair activation of gonadal hormones in the female, so that the androgen and estrogen ratio is disturbed. According to their findings, it is logical to conclude that vitamin B compounds are of benefit, as these are needed for normal ovarian function. Under normal conditions, estrogen is inactivated by the liver. In the absence of B and riboflavin, this does not take place.

Because of these findings, it has been shown by several investigators that B factors have a definite place in gynecology, especially in such cases as menorrhagia, metrorrhagia, premenstrual tension, and other conditions of hyperestrinemia.

As stated earlier, it is important to know the B. M. R. The thyroid gland affects metabolism. Lowered basal rate may cause pelvic disturbances, as mentioned before, in addition to scanty menstruation or amenorrhea. Goodall¹⁰ of Montreal states that deficiency dyscrasias of thyroid outnumber excessive secretory cases in the ratio of 50 to 1. He advocates use of small doses of thyroid in cases of meno- or metrorrhagia, dysmenorrhea, as well as for threatened abortion or during the entire pregnancy.

It is generally agreed that estrogenic hormones should not be used promiscuously, that they do have a role to play in cases of hypo-estrinism. They should definitely not be used in females in whom cancer is suspected or present, or in those women who have a familial tendency to cancer. In such patients male sex hormones, used properly, will replace estrogen. Three-hundred-fifty mg. of testosterone propionate, according to Loeser,⁷ is the maximum to be used parenterally in one month, and 600 mg. orally, unless cases warrant masculine changes, then upper limits are used.

I want to say something about dysmenorrhea and premenstrual tension. Dysmenorrhea is not only painful to the female but it is a problem to the physician. Testosterone does not seem to improve this condition. It is known that painless menstruation can be produced by large doses of estrogen to prevent corpus luteum formation. This hormone is used in the pre-ovulatory stage to suppress ovulation. Thyroid, as stated before, and sedatives, along with estrogen, are of some help. In those cases which are disabling and show no improvement and warrant an operation, then pre-sacral neurectomy should be tried. This procedure, however, does not cure 100 percent, as pointed out by Ingersol, et al,¹¹ who state that three possible cases for failure exist: "(1) psychoneurosis, (2) regeneration of sympathetic nerves, and (3) incomplete sympathectomy." The latter is due to the fact that there are anatomic variations, and the nerve is distinct in about 25 percent of cases. The same investigators conclude that essential dysmenorrhea obtains the best results, whereas the acquired dysmenorrhea, which includes pelvic pathology, ob-

tains about a 50 percent chance of relief by neurectomy. Psychoneurotics should not have neurectomy.

Premenstrual tension and bloating, which is a frequent complaint, is thought to be sodium ion retention under the influence of the ovarian steroids, according to the postulates of Greenhill and Freed in 1940. This hypothesis precludes extracellular fluid accumulation because of the sodium ion. This excess fluid gives rise to the neurological symptoms, nausea and bloating of the abdomen. Relief of these symptoms was obtained by salt restriction and giving the patients ammonium chloride two weeks before onset of menses. In addition, vitamin B factors, according to Gordon,⁹ are of importance if there is any hepatic dysfunction. However, this deficiency is not always demonstrable. As it was stated before, vitamin B factors influence estrogens, and if the estrogens are not inactivated, increase in sodium ion concentration will result.

More severe cases, and those which are near the menopause, are relieved with x-ray irradiation by producing artificial menopause.

CONCLUSION

1. Do a complete physical examination.
2. Treat the patient, not only the disease.
3. Prerequisite to vaginal treatment is teaching patients cleanliness.
4. Eradicate all foci of infection in genital tract.
5. Vitamin deficiencies are associated with pruritis vulvae.
6. Case presentation to show pruritis vulvae may be due to cancer higher up in genital tract.
7. Functional uterine bleeding is due to hyperestrinemia and should respond to progesterone and testosterone.
8. Uterine bleeding during childbearing age calls for careful history and physical, D. and C., as well as B. M. R.
9. Hepatic dysfunction prevents inactivation of estrogens, resulting in androgen/estrogen ratio to be abnormal.
10. Estrogenic hormones must not be used in females who have cancer or familial tendency to cancer.
11. Maximum dose of testosterone is 350 mg. parenterally in one month. Watch for masculinization.
12. Pre-sacral neurectomy is contraindicated for dysmenorrhea in psychoneurotics, and is not a 100 percent cure in other cases of dysmenorrhea.
13. Dysmenorrhea will not occur if ovulation and corpus luteum formation does not take place.
14. Premenstrual tension and bloating benefited by ammonium chloride, vitamin B factors, and limitation of sodium chloride.

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QUESTIONS WANTED FOR PANEL DISCUSSIONS

Physicians are invited to submit questions on the subjects of "Peripheral Vascular Diseases" and "Hospital Rules and Regulations," which will be discussed by panels on Wednesday afternoon, September 28, and Thursday afternoon, September 29, respectively, during the annual session.

The questions should be mailed to Dr. Ralph U. Leser, chairman of the Committee on Scientific Work, 207 Hume Mansur Building, Indianapolis 4, who will turn them over to the moderators. Receipt of the questions prior to the meeting will enable the panel leaders to present a more interesting program.

THE ROUTINE MANAGEMENT OF THE INFERTILE COUPLE IN PRIVATE PRACTICE*

CHARLES O. McCORMICK, JR., M.D.

INDIANAPOLIS

ONE of the principle processes of life is reproduction, without which there would be no existence of any kind, simple or complex, plant or animal. As the classes become more complex and the processes of living more specialized, survival of the species depends not so much upon being the "fittest" as upon the proper and efficient coordination of the intricate mechanism of reproduction and its complex psychologic and economic elements. In man, the reproductive process is indeed complicated.

Infertility and sterility are used at times synonymously. Meaker¹ states: "Infertility is an all-inclusive term embracing any degree of conceptive capacity below the level of physiological perfection, and so includes relative fertility, relative sterility, and absolute sterility." In the strictest sense of the word, a male is sterile if he fails to reproduce a mature spermatozoon during his reproductive era; and the same is true of a female if she fails to produce a mature ovum during her reproductive era. The permanent state of infertility is sterility, while the temporary condition is called infertility. So infertility is the relative inability, in a designated temporal period, to permit the complementary responses of the reproductive process in the male and female to attain the end process of reproduction—successful pregnancy.

From a clinical standpoint, infertility in a mating is inability to reproduce. This may be due to a single factor or to multiple factors, in either one or both partners of a mated couple. Therefore, a couple and not the individual is to be considered in the management of these cases.

Infertility is considered primary when conception has not occurred after a lapse of one year of continuous marital life without the use of any contraceptive measure. It is considered secondary in those cases in which pregnancy has occurred with succeeding failure. In the latter class may be included the one-child sterility cases, the cases of habitual abortion, the cases in which the fetus dies in utero or upon delivery, and the cases of ectopic pregnancy.

In this paper the author is dealing with primary infertility cases, although the management of some of the various types of secondary infertility cases would be handled in a similar manner.

When the doctor is consulted by the infertile couple, who is most often represented by the wife,

superficial questioning and examination are not enough to establish normality. A definite pattern of diagnostic steps must be set up which must be carried out in its entirety, unless pregnancy intervenes, or unless an irremediable cause for sterility is diagnosed. Such a program requires considerable time upon the part of the doctor, husband, and wife. It is not to be embarked upon lightly, if indeed at all, unless the patient and doctor are equipped to carry it to its successful or diagnostic conclusion.

In our office there has been developed a minimal diagnosis survey which we apply to every couple seeking treatment and having at least one year's involuntary infertility. This survey is based on certain etiologic factors that have been listed by the following authorities: Meaker,¹ Mazer and Israel,² Hamblen,³ and Siegler.⁴ These sources list the most common causes of infertility as (1) male factor, (2) the tubal factor, (3) endocrine factor in the female (hypothyroidism, abnormal menstruation et cetera), and (4) the cervical factor.

This study begins with the first office visit made by the childless woman, because she is the one who usually seeks out the physician. To her the plan of investigation and the likelihood of multiple etiologic faults are presented. She is told that active treatment will not be undertaken without strict adherence to the entire diagnostic program, even though an important etiologic clue may be found early in the course of the survey. Also, she must be impressed with the need of rechecking studies done previously through other channels, for the lapse of time may have changed the condition responsible for the barren union.

At this first visit a complete history is taken and physical examination is made. In taking the history, particular attention is paid to the following: duration of infertility, menstrual dates, premarital and marital experiences, contraception, occupation, habits, diet, operations, accidents, illnesses, x-ray therapy, medications, and treatment. Physical examination has to be thorough, with particular notations of distribution of fat and hair, the development of breasts, external and internal genitalia. Also, at this examination grossly recognizable pathological pelvic conditions, such as tumors and infections hostile to the initiation and maintenance of pregnancy, are recognized or eliminated.

The laboratory examination that is required on this first visit is a complete blood count, urine an-

* Read before the Indianapolis Medical Society, January 4, 1949.

alysis, a basal metabolism test, and a serology test if the history is indicative.

At this visit the patient is instructed to take her basal temperature daily. She is told in detail how to take her morning temperature and why she's taking it—for the purpose of determining her time of ovulation. At this time it might be mentioned that there is some question as to the ability of the basal temperature to predict accurately the time of ovulation in over 50 percent of the cases. Nevertheless, at the moment it is the most practical clinical test that is offered for determining this phenomenon. Besides, this test does give the patient something to do over the months, thereby relieving to some extent her mental anguish as to whether or not she will be able to conceive.

First it is made certain that the patient knows how to read a thermometer. Then she is instructed to take her temperature orally at the same time every morning, on awaking, after at least six hours of restful sleep; i.e., before she gets up to go to the lavatory, or before she rolls over in bed to kiss her husband, or even before she throws back the covers. She leaves the thermometer in her mouth for three minutes, with lips closed, at the end of which time she records her temperature on the chart given her. This chart records the reading in fifths of a degree.

The correlation between the basal body temperature and gonadal function is based on the observation that during the estrogen phase of the menstrual cycle the basal temperature drops progressively or remains on a level. The low point is reached just before ovulation.² After ovulation, during corpus luteum activity, the basal temperature rises suddenly, or more often gradually, often reaching a level of one degree Fahrenheit above the lowest point of the estrogen phase. The temperature stays at this level until one to two days before menstruation, at which time it drops to the preovulatory level due to the regression of corpus luteum. After the temperature reaches its highest level and remains at that level for sixteen additional days, it can be stated that pregnancy has occurred. This is often referred to as, "The poor man's Friedman test."

Also recorded on this chart are the days that coitus occurs, by encircling the temperature dots. This gives a clue as to whether the couple is having too frequent or too few acts of coitus.

Any cause, such as a cold, marked indigestion, or insomnia, that may influence the basal temperature is recorded on the chart.

The patient is asked to keep her temperature for at least two months, preferably three months, and she is told to bring her chart with her on each office visit.

If the woman's menstrual cycle is fairly regular, she is instructed to have coitus on two successive days of the midcycle with five previous days of coital abstinence. These instructions are carried out for the first few months until the ovulation day can be predicted on the temperature graph.

If at this first office visit no incurable cause of infertility is discovered, the patient is told that the next step in this investigation is the examination of her husband's semen. The instructions are as follows: after five days of abstinence of coitus and of nocturnal emissions, the husband is to collect manually a semen specimen into a previously cleaned, dry, cold cream or ointment jar. After the lid has been placed tightly on the jar, the jar is to be brought into the office within one to two hours for examination. During transportation to the office, the jar should not be packed in ice or heat, but rather carried in the pocket or purse of the transporter. If it is impossible to get the specimen to the office within the limited time, the specimen may be collected in the office.

In examining the semen, the author uses Farris's technic.⁵ This technic consists of measuring the volume, estimating the viscosity, determining the number of both the active and inactive sperm, determining the drive of the active sperm, and determining the number of abnormal forms of sperm by studying the stained smear. Before examining a specimen, wait at least one hour after collection for liquification of the semen. The technic of the semen examination is as follows:

Volume. The volume is measured in a 10 cc. sterile glass syringe. One-fourth to $\frac{1}{2}$ cc. is sealed in a 1 cc. glass syringe, for a 24 hour estimate of motility. The specimens are kept at room temperature. Normal standard is 2 to 4.5 cc.

Viscosity. The semen is stirred with a wooden applicator, and its viscosity is judged by withdrawing the fluid from the surface of the specimen. Normal semen is of a rather viscid consistency.

Estimated Motility. A small, well-mixed drop of undiluted semen is placed on a clean glass slide and covered with an 8 by 8 mm. cover slip. Sperm motility is estimated and graded as the percentage of moving cells.

Count of Moving Cells. The sperm cell count is made like a blood count, using an automatic Treanor white pipette (1:20 dilution) and a Spencer Bright-Line Haemocytometer. A 16 mm. objective is used for the counting. A yellow filtered light is preferred to daylight.

For the diluting fluid, Locke's is selected to keep the spermatozoa alive, active and normal, thus permitting a differential count of both the active and inactive sperm. For preparation of Locke's fluid the reader is referred to Farris's original article.⁵

The supporting ribs of the counting chamber are coated with a thin film of "Salvoline," and the glass cover slip pressed into position.

The well-mixed semen is diluted 1:20, as follows: it is drawn to the 0.5 mark on the automatic pipette, with the addition of enough Locke's fluid to fill the pipette. After thirty seconds of mixing, the first two drops are discarded, and the mixture is flooded onto the counting chamber. It is fre-

quently difficult to suck unusually viscous specimens to the dilution mark without lifting the pipette from the semen. The ends of the counting chamber are sealed with Salvoline. The sperm maintain their motility for many hours, as many as eight to ten, in this sealed preparation.

The sperm are counted in five groups of sixteen small squares in the red field. The four groups in the corners, and the fifth in the center are counted routinely. Both chambers are counted and averaged. The active cells in the first block of sixteen small squares are counted, followed by a similar count of the inactive cells. The active cell count is repeated. The two counts of the active cells should always be in close agreement. The higher of the two counts is the one selected.

The count is begun in the upper left hand square of the block, continued across to the right, followed by the second row from right to the left, and so on until the four rows are counted. An occasional spermatozoon may be out of focus. However, the blur of such a sperm is easily recognized. An active sperm is one showing any sign of motion.

Six zeros are added to the number of the active and inactive cells in the five blocks (80 small squares), as in counting blood. This gives the number of sperm per cc. By dividing the number of active cells per cc. by the total count per cubic centimeter (active + inactive), and multiplying by 100,

$$\frac{(\text{active per cc.})}{(\text{total per cc.} \times 100)} \times 100$$
 the percent of motile cells is obtained. The product of the volume of the ejaculate, the number of cells per cubic centimeter, and the percent of motile cells gives the total number of moving cells in the ejaculate.

The highly fertile male is one who averages above 185 million total moving sperm per ejaculate. The relatively fertile male is one possessing a total between 80 and 184 million moving sperm per ejaculate. A subfertile male is one possessing a total between 1 and 80 million moving sperm per ejaculate. A sterile male is one who has no motile sperm.

Check on the motile sperm count. All sperm in another sample are fixed and counted. The fixing agent is a saturated solution of sodium bicarbonate plus 1 percent phenol. The count of the fixed cells should not vary more than 5 percent from the count of the active and inactive cells in the Locke's fluid preparation.

Speed or drive. The character of the sperm motility also is studied. Five sperm are timed in each of the five blocks of squares. A sperm is followed until it is observed to be moving directly across the field. It is timed by a stop watch, from the time the tip of the head touches one side of a small square until it reaches the other.

Normal sperm move forward, usually, in a relatively straight, undeviating course, while abnormal ones circle, oscillate, weave, and show other aberrant movements.

The motion of the normal, forward-moving sperm is classified as aggressive, progressive, or sluggish, depending upon its speed in crossing a square $1/20$ of a mm. in diameter. The aggressive sperm covers this distance in 1 second or less. Progressive sperm cover the same distance in from 1 to 1.8 seconds; sluggish sperm require 2 seconds or more.

Morphology. The comparative morphology of the sperm is studied from stained smears prepared according to the method outlined by Hotchkiss, utilizing Schaudin's mercury bichloride fixative, and the eosin-Harris hematoxylin stain. However, the author has been using the alcoholic fuchsin stain, advocated by Kantor,⁶ because of its simplicity and the rapidity with which it stains.

Three hundred individual cells are examined under oil immersion, and classified according to the system used by Hotchkiss. He considers the oval sperm to be normal. Abnormal sperm fall into six classes, as follows: giant, pinhead, round, tapering, duplicate, and amorphous.

For a specimen to be considered normal, the percentage of abnormal sperm should be 20 percent or less.

Duration of Motility. The sperm are examined at regular intervals to determine the duration of their motility (4-6-24 hours). If it is reduced markedly, an estimate is made of the number of moving cells, rather than an actual count. The motility in a good specimen lasts 4 to 6 hours.

A specimen is considered to be highly fertile when: (1) the total number of active sperm per ejaculate is 185 million or more; (2) the percent of motile cells is 45 percent or above; (3) the average drive of the sperm is 1.2 seconds per $1/20$ mm. or less; and (4) the percentage of abnormal forms is 20 percent or less.

If a specimen is borderline (total active sperm = 80 million to 184 million, average drive = 1.3 to 3 seconds, percentage of motile sperm = 25 to 44 percent, and percentage of abnormal sperm = 20 to 30), it is rechecked.

The husband is referred to the urologist for further study when he has two borderline specimens or one poor specimen; i.e., the standards of the borderline specimen are not met.

If he is referred to the urologist, study and treatment of the wife are suspended until the husband meets the requirements of a normal semen specimen.

When the husband meets these requirements, the wife is instructed to return for her second office visit to determine the patency of her fallopian tubes.

This test is not performed if any of the following conditions exist: (1) acute or chronic pelvic disease, including chronic cervicitis, as well as acute or chronic vaginitis, (2) presence of uterine

bleeding in any form, (3) history of mild reaction following previous insufflation tests or endometrial biopsy, (4) serious cardiac or respiratory diseases, and (5) an interval of less than 3 to 4 weeks after an intrauterine manipulation.

The technic of the test is as follows: after a pelvic examination has been done and the position of the uterus determined, the patient is placed in slight Trendelenburg position. The cervix, after being exposed with a bivalve speculum, is cleansed with dry, sterile cotton, and painted with an antiseptic. After grasping the cervix with a teneculum, the cervical canal is dilated with a sterile uterine sound. A sterile, modified Keyes-Ultzmann type of cannula, which has been previously connected with a hand bulb and Tycos manometer, is inserted into the uterine cavity, barely passing through the internal os of the cervix. The vagina is then filled with enough sterile solution of boric acid to cover the external os of the cervix. While an assistant listens with a stethoscope suprapubically for the escape of air through the tubes, air is pumped into the uterine cavity not to exceed a pressure of 220 mm. of mercury. If the air goes through at this level of pressure or lower, the rapidity with which the needle on the manometer drops is noted, as well as the low level to which it drops.

A normal is considered when the pressure ranges
120-140

from 70-80 mm. of mercury and the needle drops rapidly. No more than three readings are taken at this one office visit. We have used air for at least two and one-half years safely, although carbon dioxide is preferable.

It is also noted if the patient experiences any pain in either one or both shoulders before leaving the office, although there is some question as to the patency of the tubes even in the presence of shoulder pain.

If any reaction other than normal is obtained, this test is repeated at the same time as the menstrual cycle for the next two consecutive months before studying her problem further.

If after three tests the tubes are still nonpatent, uterosalpingography is recommended to determine the point or points of obstruction to see if surgery might be indicated as well as a therapeutic measure. The contraindications to this procedure are the same as for tubal insufflations.

The technic for doing an uterosalpingography is as follows: the patient is placed in the lithotomy position on the x-ray table and the cervix is exposed, cleansed, and grasped, as has been described in preparing for a tubal insufflation. A sterile Hudgins cannula is "screwed" into the cervical canal, and 7 to 10 cc. of sterile Rayopak is injected slowly and carefully, filling the uterus and tubes. Formerly this injection was done under fluoroscope, but has since been discontinued. As soon as the media has been injected, anterior-posterior

and lateral x-ray films of the pelvis are made immediately, and twenty to thirty minutes later. The second films are taken to determine the presence or absence of the spill of the media into the peritoneal cavity.

If at this second office visit the patient has patent tubes, she is given instructions for the Huhner test, which will be done at the next visit.

By this time, the temperature chart may be of some help in determining the time of ovulation; for this is the optimum time in performing this test. If the temperature chart is not helpful, the test is performed as near ovulation time as can best be estimated, the reason for this being that cervical mucus is most receptive to sperm at time of ovulation.

In performing the Huhner test, the patient is instructed to abstain from coitus for five days before the test. On the day of the test, she is instructed to have coitus in the prone position with a pillow beneath her hips. She is to lie in this position for thirty minutes following coitus, and then sit up and put on a perineal pad. No tampon or cotton sponge is to be used, nor is a douche to be taken. Previous to coitus she has emptied her bladder and bowels. She is to report to the office within four to six hours following coitus.

Upon reporting to the office, the patient is placed in the usual lithotomy position. A dry, sterile, bivalve speculum is inserted into the vagina and the seminal pool in the posterior fornix is exposed. A specimen from this pool is aspirated by means of a dry, sterile pipette and placed on a microscopic slide under a glass cover slip. This specimen, when obtained five to six hours postcoital, shows normally a considerable number of nonmotile spermatozoa per high power field. This indicates that the semen has been properly deposited.

Next, the area around the external cervical os is wiped clean with dry absorbent cotton. At this time one can get an idea as to whether favorable or unfavorable cervical mucus exists, depending on the amount, appearance, viscosity, and Ph of this mucus.

After the preceding observations have been noted, a specimen of cervical mucus is aspirated from the cervical canal by means of another dry, sterile pipette. This specimen is then placed on a slide, covered with a cover slip which is surrounded with vasoline, thereby making it airtight.

The presence of a certain number of migrating, not merely motile, sperm per high power field in this cervical specimen indicates: (1) the invasive power of the spermatozoa, (2) the absence of mechanical interference with their ascent into the cervical canal, and (3) the absence of hostility of the cervical secretions. This number is quite variable, according to various authorities, ranging from 5 to 50 motile sperm per high power field.

It has been stated that the endocrine factor in the wife is partly or wholly responsible for about 25 percent² to 30 percent³ of involuntary barren marriages. So, if the wife has shown an atypical temperature chart as well as given a history of menstrual irregularity, an endometrial biopsy may be of considerable help. In addition to being a helpful adjunct in diagnosis, endometrial biopsy will be useful in the follow-up care of certain therapy programs.

At this third office visit, instructions are given to the patient as to the obtaining of the endometrial biopsy.

Technic. The patient is told to come into the office on the first day of menstruation within twelve to eighteen hours after the onset of flowing. After the patient is placed in the lithotomy position, the cervix is painted with an antiseptic, grasped and steadied with a tenaculum, and the cervical canal is dilated with an uterine sound. Novak's suction curette is introduced into the uterine cavity, and several strips of endometrial tissue are removed from the anterior and posterior wall of the fundic portion of the uterus. These strips are placed in a 4 to 5 percent solution of formalin and are sent to a competent pathologist. Needless to say, if the physician reviews these tissues, he will be able to follow his patient more satisfactorily.

This biopsy determines the occurrence of ovulation or its absence that month. If this biopsy can be taken in conjunction with the temperature chart, more knowledge is gained. Occasionally tuberculosis or a tumor is discovered in this tissue, but usually a study of the progesterational effect on the endometrium is the aim of the test.

In conclusion, I would again like to state that the proper management of the study of the infertile couple, and it is the couple and not just one member of the couple that is to be studied, is time-consuming for the doctor, wife, and husband. Therefore, this study is not to be taken lightly or handled by just superficial questioning and a pelvic examination of the wife, and told, "There is no reason why you cannot get pregnant."

We herewith submit an outline for the minimal study of the infertile couple.

MANAGEMENT of INFERTILITY

I. First Office Visit

- a. *History:* Dur. Infert.-Menst. Dates
Contraception-Marital Experiences
Occup.-Habits-Diet-Operations
Accidents-Illnesses-Prev. Treatment
- b. *Phy. Exam.:* Heart-Lungs-Pelvis-Etc.
Distrib. Fat, Hair-Devel. Breast, Ext.
& Int. Genitalia.
- c. *Laboratory:* C.B.C.-B.M.R.-Urine-Wass.
- d. *Instruction:*

1. Basal Temperature
2. Optimum Time-Coitus
3. Collecting Semen.

II. Semen Examination—(Farris method)

- a. Volume b. Viscosity
- c. No. Act. & Inact. Sperm
- d. Motility (%) e. Abn. Sperm (%)

III. Second Office Visit

- a. Tubal Insufflation
- b. Instruction-Huhner Test

IV. Third Office Visit

- a. Cervical Mucus
 1. Ph
 2. Viscosity
 3. Appearance
- b. Huhner Test
- c. Instruction-Endometrial Biopsy

V. Fourth Office Visit

- a. Endometrial Biopsy
- b. Outline of Treatment

VI. Other Office Visits and Procedures

- a. Repeat Tubal Insufflations
- b. Uterosalingography

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Attend the Instructional Courses on the First Day of the Centennial
Session, September 26th

UROLOGY IN GENERAL PRACTICE

JOHN I. WALLER, M.D.

INDIANAPOLIS

SINCE most of the common pathological conditions of the genito-urinary tract are to be seen frequently in the office of the general practitioner, it might be well to consider some of these problems and their management.

ACUTE GONORRHEA IN THE MALE

One of the most common of these is that of acute gonorrhea in the male. This disease is becoming more and more a problem which is treated in general practice. I well remember that this disease was one of the most trying and difficult conditions that came into the office before the days of sulfonamides and penicillin. In those days the patient with gonorrhea came in for treatment after having tried all the "cures" suggested by friends. I recall that one of my patients had been told that he would be cured of his disease if he allowed a window sill to fall on his penis. This he did and you can imagine the result. Another had been told to inject gasoline into the urethra. I often had to treat the "cures" as well as the primary disease. It took from six weeks to six years to cure gonorrhea then, and in the meantime the patient spread his disease far and wide. Severe strictures and major complications were common. Now the disease is being treated, and well, by penicillin, in the office of the family physician. So well is it being treated that future generations of medical students may have to look hard to find a stricture due to gonorrhea. No more does the patient spread his disease for months while he is being treated.

Duracillin in single doses of 300,000 units will usually bring about a prompt cure. The occasional case which does not respond to treatment still becomes a problem for the urologist to solve.

CYSTITIS IN THE FEMALE

Cystitis in the female is probably one of the most misunderstood and mistaken conditions dealt with in general practice. A great many of the women who come to the office of the physician in a small town will tell him about their "cystitis." Many of these cases are self-diagnosed or have been made by a physician without much study of the case. A few years ago Kretschmer¹ made the statement that cystitis in females was a very rare condition. Most of these bladder symptoms are due to some underlying cause and the cystitis is only a symptom of the real disease. These patients should have

the benefit of a complete urologic work-up. The frequency, urgency, burning, and pus in the urine may be the warning bell that means serious disease elsewhere in the urinary tract. I once had a patient who had been treated for cystitis for years with no results. I cystoscoped her and found a large foreign body in her bladder. This I removed and she was cured of her cystitis.

If the symptoms described above are due to cystitis alone the condition may be treated by rest in bed, hot sitz baths, ample fluids by mouth, alkalization of urine, Tincture of Hyoseyamus, and sedatives. Sulfonamides will help if the condition is due to one of the bacteria susceptible to that drug. Instillations are used too often and most cases of acute cystitis will be better off without them.

URINARY CALCULI

Kidney or ureteral stones are frequently seen in the practice of the family physician. Renal colic is an old story to him and he can make the diagnosis over the telephone, as a rule. He is more apt to miss the stone which is silent. There are several things that one should remember about such cases. Even though the morphine, dolophin, demerol, or depropanex, which may have been used to control the pain, gives relief, the patient should have a flat x-ray taken to determine the size and location of the calculus. The urine should be examined for the presence of fresh red blood cells. An intravenous pyelogram will give an idea of how much damage has been done to renal function.

The back pain of sacroiliac origin that the farmer has, who carries heavy feed sacks or buckets of milk, should not be confused with renal disease. A stone in the lower right ureter is easy to confuse with appendicitis. The problem becomes more difficult if the calculus is one which does not cast a shadow on the x-ray film. In such a case, a ureteral catheter with a wax tip can be passed up the right ureter to see if one finds obstruction or gets a scratch on the wax tip. If all this is done and there still is doubt, the only safe thing to do is remove the appendix. When one believes that he may be dealing with an early ruptured appendix, he is not prone to wait very long to see if a stone might pass.

Gallstones may be confused with stone in the upper third of the right ureter. X-ray will remove this doubt.

Herpes in the loin may be mistaken for renal disease before the eruption takes place.

* Read before the Orange County Medical Society at West Baden, on April 6, 1948.

HEMATURIA

The patient with hematuria always deserves cystoscopy and x-ray to determine the source of the bleeding. There is always some good reason why a patient has blood in his urine. The fact that hematuria stops following some type of medication is no reason for procrastination. A tumor may bleed one day and not bleed again for weeks or months. Then it may be too late to treat. One should never give medicine to stop hematuria. It gives the patient a false sense of security. Often these patients do not seem to be very worried about seeing blood in the urine. They feel fine and have no complaints, except the hematuria. If they had severe pain with a lesser condition they would be more alarmed.

Hematuria may mean tumor, stone, tuberculosis, ulcer, prostatic disease, nephritis, and many other serious conditions. The treatment is that of the underlying cause.

PROSTATITIS

Chronic prostatitis is frequently seen in the office. Rectal examination will reveal a soft, boggy prostate, whose secretion, after massage, will show many pus cells to be present. One will often be surprised to find that routine massage of this type of prostate will gradually reduce the amount of residual urine. These cases must be massaged at regular intervals over quite a long period of time. This serves to evacuate the pus-filled gland and relieve congestion. One should be gentle at first and massage only once or twice a week, later extending the periods between massages to once every month or more. Gonorrheal infection of the posterior urethra is a common cause of the condition. The gland becomes infected with secondary bacteria and these persist long after the gonorrhea has ceased to be present. In other cases the infection in the prostate is due to some distant focus of infection, such as teeth, tonsils, sinus, or bowel. In these cases the source of infection must be removed if one is to cure the patient. The prostate itself may be the focus of infection causing an iritis or arthritis. If this should be the case, too severe massage of the prostate may cause a marked increase in the symptoms of the other disease.

URETHRAL STRICTURE

Strictures of the male urethra consist of scars in the urethra, usually the result of some previous infection. They may also be of traumatic or congenital origin. One will see all sizes of strictures, from large to small, or even filiform. If a number 20 sound will pass, but is tight, the stricture is considered a large or open one. If a number 20 sound will not pass, the stricture is a small one. In small strictures, smaller size sounds may be used, but it is much safer to use a whip or some flexible type of instrument. The strictures may be multiple in number.

Gradual dilatation of these strictures usually brings prompt relief. However, sounds may be dangerous weapons if one is not careful in their use. They should only be passed with the utmost gentleness and care. They should never be forced, but should be allowed to slide into the bladder. There are many ways of starting to pass a sound. It matters little how one begins. A simple and easy method is to grasp the sound by the handle with the right hand and place the little finger of the right hand on the umbilicus of the patient. Holding the glans penis in the left hand, the tip of the sound is placed in the urethra and the penis¹ is pulled up onto the sound as far as it will go. Then an arc is made with the right hand and the tip of the sound is allowed to slide into the bladder. If the sound can be rotated from side to side one knows that the tip is in the bladder.

Sounding should be repeated from once a week to once a month or more, depending on the response. The stricture should not be dilated from very small to large size too quickly. At each visit one may dilate up to about three sounds larger without trouble. The recontractile tendency of a stricture should be explained to the patient and he should understand just what you are trying to accomplish for him. He may have to be sounded for years to keep the urethra normal in size.

PROSTATISM

There are more cases of prostatic hypertrophy which have never been in a urologist's office than is commonly known. Speaking as a general practitioner, who now limits his practice to urology, I know how difficult it is to convince the average male that he needs prostatic surgery. Here again the patient usually feels well except that he has trouble in voiding. He usually is able to work and go about his business. Even though he carries too much residual urine and must strain hard to void, he wants to postpone surgery until he gets complete retention. Even then, he must be convinced in his own mind that his condition is hopeless and that his act of voiding will not return.

The psychological reason behind all this is easy to understand. He has already made up his mind that he is too old to undergo surgery, unless there is no other way out. Perhaps he has had a coronary occlusion or other heart disease. Urology as a field of surgery has grown from its infancy during most of these old men's lifetime. Their fathers and elder friends often died when they were subjected to prostatic surgery before the days of modern care and treatment. In the small town in which I did general practice all my older male patients would tell me the names and histories of those patients who had had unsatisfactory results from prostatic surgery. Even one elderly physician who was deceased, but who had practiced there all of his life, was always given as an example.

These patients should be told that no more is a man too old to undergo prostatic surgery success-

fully. Transurethral resection, blood chemistry, fluid balance, blood transfusions, electrocardiograms, and chemotherapy have made it possible to operate on much older men with a mortality which is no higher than for other types of surgery in younger patients. These patients are often up on the first postoperative day and suffer very little discomfort. They may return home on the tenth to fourteenth day and proceed to live a comfortable, normal, and useful life.

As to the diagnosis of prostatic hypertrophy, the patient will usually give a history of having to get up several times at night to void. He will have to void frequently during the day. The stream will be slow to start and the force of the stream will be slight. He may complain of pain and burning on voiding. He may have urgency and trouble in keeping his clothes dry. He may or may not have hematuria. A rectal examination will reveal any degree of enlargement from Grade I to Grade IV. The prostate may be soft and plastic if benign, or hard, nodular, and indurated if carcinoma is present. A simple method of grading prostatic hypertrophy is what I call the citrus fruit method. In other words, a prostate the size of a lime is Grade I; the size of a lemon, Grade II; the size of an orange, Grade III; and the size of a small grapefruit, Grade IV. This, of course, is a rough estimate, but it gives some idea of the size gland to which one refers.

One may check the residual urine by having the patient void three times and then at once pass a catheter and see how much urine remains in the bladder. This is a very accurate way of determining bladder neck obstruction and means much more than the rectal examination. The patient with three ounces or upward of residual urine should be examined by the urologist.

It is well to remember that there is no direct relationship between the size of the prostate as felt per rectum and the amount of obstruction found at the bladder neck. A large prostate as felt

per rectum may cause less obstruction to the passage of urine than a smaller one, providing the lobes of the small prostate grow into the urethra in such a way as to obstruct it. A prostate that is normal in size as felt per rectum may cause obstruction and too much residual urine due to the fact that a large middle lobe or median bar is present. These are facts that are well known to all urologists but should be called to the attention of most men in general practice.

I will not go into the various methods of treating or operating prostatic hypertrophy and carcinoma of the prostate once the patient is in the hospital. This is a problem that the urologist will handle in the best interest of the patient, and volumes have been written on the subject. All of the techniques that are used have been greatly improved in recent years, and in competent hands it is reasonable to expect good results.

SUMMARY

This paper was written as a brief review of some of the common problems in urology which confronted the author during twelve years of general practice. Lengthy accounts of theories and rare conditions have been avoided. The problems discussed in abstract are:

1. Acute gonorrhea in the male.
2. Cystitis in the female.
3. Ureteral calculi.
4. Hematuria.
5. Chronic prostatitis.
6. Strictures in the male urethra.
7. Prostatism.

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- 407 Hume Mansur Bldg.,
Indianapolis 4, Indiana.

The Instructional Course Schedule is on Page 804 of This Issue.

See It Now!!!!

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

LOOKING FORWARD WITH THE GENERAL PRACTICE OF MEDICINE

IN THE bygone years of medical practice the man at the grass roots, the general practitioner, has always been the work horse. He has cared for numerous patients—both rich and poor, in high places and in low, many times without recompense other than the satisfaction gained through being of service to his fellow man. He has made some mistakes and on the other hand has at times been brilliant in discoveries he has brought to the complex field of medical endeavor. He has many times veered off into some interesting and, to him mysterious, realm of medicine and become a great specialist in that one particular phase of interest. But more than anything else, he has without fail been the bulwark upon which medicine has been built. From the rural to the big city practitioner it has taken a great deal of intestinal fortitude and common, day-by-day plugging ahead to accomplish the marvels of today. No miracle has ever been gained by dreaming or by government decree. So it has been with medicine—great heights have been attained—by unselfish devotion to duty by physicians through the centuries.

In later years the man in general practice has had to work harder to increase and renew his knowledge in order to keep abreast of the rapidly changing concepts of practice and the newer, better treatment of disease. Yet he still has time to look forward to still newer and better horizons. It has been borne in on him that he must constantly strive toward enlarging his knowledge and improving his techniques. He has learned that medical science has so broadened that he cannot encompass it all and at times is benefited by specialized knowledge in consultation. But withal he has constantly remained the *family doctor*—the very center of medical endeavor.

The practice of medicine has changed, it has broadened, it is different both economically and qualitatively. It has changed of course because of new discoveries, but it has also changed because of a generalized world economic and social upheaval. Whether or not we agree entirely with parts of the upheaval, we must at least admit to ourselves that such has taken place. We absolutely must adapt ourselves to it in such a way that we can carry

forward the practice of medicine to the best of our abilities and for the most benefit to the public. Crying will avail us nothing, whereas a down-to-earth willingness to work and to cooperate one with another will be our salvation. As medicine has advanced it has increasingly stimulated men to more complete investigation in one or another direction. What one man accomplishes, we all take advantage of for our patients. It has always been unselfish work that has paid us dividends and has accrued to the good of the people we care for. We should always manage our affairs as general practitioners so as to carry on the traditions which we all respect.

Looking forward with general practice brings up some factors that should be given thought. First, and due in part perhaps to the aforementioned social and economic changes, there has been a tendency to overspecialize. It is surprising to note that in the larger cities of Indiana there is actually a preponderance of specialists—the ratio being 60-40, or perhaps more, on the side of specialists. Although of course specialists per se are in the minority in general, such a tendency to overspecialize in many areas certainly is at least economically unsound. This is evidenced on occasion when a man who has spent several extra years in specializing gives up his attempt to practice his specialty, because of economic reasons, and reverts to general practice or takes a salaried post. It is not evidence of sound judgment to encourage overspecialization nor to discourage the student of medicine from becoming a good general practitioner.

It is felt that one of the big reasons for the above trend is the attitude prevailing in both medical school and hospital teaching. The young student is given very little stimulus toward general practice because of the very natural tendency of the teacher specialist to emphasize or possibly at times over-emphasize his own field of medical endeavor. This is only a natural tendency but should be leavened somewhat by a stimulus to do general practice. At least no fear of doing general practice should be inculcated in the mind of the young student. Many times we have personally heard men say that the reason they were going to specialize was because they were afraid to do general practice. This is an ambiguous and misleading statement, indeed. Specializing requires extra years and effort in the particular subject, yet a man expresses himself as being "afraid" to do general practice. Why? There is evidently not only a tendency in medical school to overemphasize each individual field, but at times actually to discourage an idea of becoming a general practitioner. Many leading medical men have expressed themselves as believing that all who specialize should first spend three to five years in general practice. They feel that this period of work, with its close family and all-around medical thinking, will make for a better specialist. Yet even the proponents of this idea have offered no solution to the problem. We believe that accomplishment of a solution of the economic and physical

aspects of the above rests in amplifying and expanding our medical school teaching to include a chair of general practice, or at the least a general practice representative. The "Art of Medical Practice" and "Economics of Practice" are two very worth-while subjects that could be given by such a representative, and proper encouragement could be given to the student toward doing general practice. Certainly a common sense attitude should be adopted on the degree of specialization and ways implemented to guide coming doctors.

A second factor that should be given some thought is that of the preceptorship. This method of teaching is becoming more established in this country and offers a marvelous opportunity to young men to enlarge their knowledge and supplement their experience. Two types of preceptorship should be offered—one between the junior and senior year and one after graduation. If a man in medical school could look forward to such an opportunity to work and study under a general practitioner he would feel more capable of entering general practice. The question of screening of men in practice who could carry out this training and the question of recompense would of course have to be studied. This is a factor of importance and should be put into the hands of a proper committee for evaluation and decision. The preceptorship is a most valuable method of supplementing our medical education—since theory and practice are not easily put together until experience has played its part. A great deal of experience can be gained in a preceptorship.

A third factor of importance in the training of the general practitioner is the establishment of a general practice residency in our hospitals—preferably for two years. This has already been accomplished in many hospitals over the country and should be seriously studied in the others.

Digressing from the foregoing discussion but still remaining in the realm of help to the general practitioner is the following: In the years since the last war it has become increasingly difficult for the average doctor to do the simple laboratory tests in his own office because of inability to obtain technicians. It is not possible or feasible to employ a regular trained technician in the average office, yet it is desirable to be able to do c.b.c.'s, urinalyses, and B.M.R.'s, at least. Other, more technical tests may be obtained elsewhere. To solve the problem it is suggested that the University Medical School laboratory and others accept office nurses at an individual doctor's request and give them training in the simple procedures outlined. Training of these women would not interfere with nor undermine the regular technician. Such a program would serve to give us technician-aides, just as we have had to develop more and more the nurse-aide. Doctors in practice outside of cities would be particularly benefited, but all would wish to take advantage of the extra help in their everyday practice.

All in all, the above suggestions should help to elevate the general practitioner's knowledge and ability to practice good medicine. Standards are, and have to be, constantly raised. We may speak of general practice as a specialty in itself, and as such, things must be done with an eye to making and keeping it, as it always has been, a field of medical endeavor of which to be mighty proud.

Arthur N. Jay, M.D., Indianapolis.

ROUND-THE-CLOCK MEDICAL SERVICE

THE medical societies of Indiana have rendered a significant public service by arranging for the receipt of and prompt response to emergency calls. In the past some criticism has been occasioned by difficulties in obtaining emergency medical service on doctors' days off and on holidays and week ends.

The remedy for this situation has been one of the planks in the public relations program of the State Association. In order to issue press releases on the progress of this part of the program, the Committee on Publicity has conducted a survey among the county societies of the state.

The results of the survey were recently reported to the newspapers of the state. News stories and radio comments have already appeared. At the present time, 84 of the 92 counties of Indiana have an organized setup for the handling of emergency calls 24 hours a day.

The data collected by the Committee is published elsewhere in this issue of THE JOURNAL. One of the most significant points to be noted in this compilation is the variety of ways and means which have been adopted to solve the problem.

The basic problem naturally varies in different communities due to variations in distribution and occupation of the population. The county societies have taken these and other variants into consideration and have made plans which utilize the best means at their disposal.

A few of the societies have found that their communities are not in need of any special organization for this purpose. A review of the report will show that the county societies have studied the situation and are either applying a remedy if needed, or are planning to do so.

The advantages of the round-the-clock medical service, for the good of the patient, and for the maintenance of good public relations, are obvious. It is to be hoped that the county society plans are 100 percent complete by the time of the Centennial Meeting this fall. Indiana may take pride in the progress that is evidenced by this report.

GENERAL PRACTICE RESIDENCY

THE American Medical Association, through its Council on Medical Education and Hospitals, has announced a plan for the recognition and standardization of the residency for general practice.

The inspiration for the establishment of such a residency is of fairly recent origin. During the few years in which postgraduate training of this nature has been developing, its value and popularity have been amply demonstrated.

The need for residency training to prepare doctors especially for general practice has been realized particularly since the close of the war. No doubt a considerable part of the postwar rush to specialty residencies was occasioned by doctors just out of an internship who felt the need for more training. Since residencies for general practice were not available, specialty residencies were sought.

The AMA Council has not only released a list of approved general practice residencies, but has also specified the essentials for such a residency. Specifications for all types of postgraduate training are important; for this new type of residency they are of utmost importance.

A good general practice residency should not consist of an extended internship. Also, while it must contain some training in the specialties, such as internal medicine, surgery, gynecology and pediatrics, to mention only a few, it should not consist of a series of short term residencies in the various specialties.

Of all the residencies, the one designed to train for the general practice of medicine will be the one which will require the most careful planning, and will demand the largest expenditure of careful teaching on the part of the hospital staff.

In this connection the Council has announced that it is discontinuing approval of general or mixed residencies. These were, for the most part, approved in the past for small hospitals, and afforded a minimum in training. Substitution of a well-organized residency for general practice will greatly increase the training potential of these hospitals.

Since preparation for general practice should include in-patient services in both private and charity hospitals, as well as large out-patient services, it is probable that several hospitals of different types may associate to provide a well-rounded program.

Editorial Notes

SHALL CONGRESS "BISMARCK" AMERICAN MEDICINE?

27th District, New York

The President has said America should try socialized medicine. So Congressmen are looking into the matter. Some of the things they are finding are curious.

The first modern nation to try what the President has recommended was Germany—under that famous "democrat" Prince von Bismarck. What was the result? Certainly socializing medicine made the government bigger and bigger. But back in 1885 the average German who became sick got well in 14 days. By 1920—after 35 years of socialization—it took him 20 days. By 1932 he needed 29 days of government medicine before he was able to work again.

Under our present medical system here in America, few of us stay home unless we are really sick; few are so foolish as to call in a doctor unless we really need one. Yet in spite of our pathetic faith in individual responsibility, year after year the death rate in America has been dropping. Contrast this with what took place in Germany after medicine was socialized. In spite of the great increase in medical knowledge, statistical sickness increased. The biggest jump in sickness came before weekends and holidays. After 50 years of socialized medicine, the average German was out sick 70 percent more days than the average American worker. Having the government pay his medical bills hasn't seemed to improve his health.

Sickness is a difficult thing to measure. Perhaps statistical sickness is something more than sickness. Those who are most familiar with the matter say that with the government paying doctor, hospital and sickness benefits, official sickness often becomes indistinguishable from a paid vacation. As an example they cite the German experience in 1930.

That was a depression year in Germany. Increased unemployment and decreased contributions created a budget emergency. There wasn't enough money coming in to pay everybody's medical bills. So an emergency decree was issued effective September 1. It required insured persons, formerly treated "free," to pay in addition to their regular contributions 12 cents for their first visit to the doctor. The result was amazing. Here's what happened in one typical community. During the last week in August the doctors had 30,300 patients. The first week after the 12-cent charge went into effect, the number fell to 8,800—a drop of more than two-thirds!

It is easy to see why overworked German doctors frequently ignored urgent pleas for help. They even left their phones off the hook. As one doctor said, they knew "that between 65 and 70 percent of all calls are unnecessary. The government pays for them and here is the important part. They prevent adequate medical care for the really sick. The treatments are mostly palliative, rarely curative, and no time is spent in personal hygiene and preventive medicine."

Another authority tells about a spot check in 2,008 so-called "patients" out sick. When interviewed, 816 at once admitted they were no longer sick. Upon examination, another 289 were declared "well." More than half were not really sick. On the other hand, one patient declared officially recovered died two days later.

Such deplorable abuses naturally call for drastic controls. Inspectors and detectives are added to the payroll. Doctors and patients are checked and counterchecked. By 1931 Germany had more clerks than doctors on the "medical" payroll! The insurance fund employed a doctor or bureaucrat for about every 250 insured patients. Yet the official amount and length of sickness had increased. In depression years, the scheme became in reality a system of unemployment relief with doctors cast in the role of detectives. And last but not least, it was a mighty step on the road which eventually led to National Socialism and Adolf Hitler.

No wonder many Congressmen are asking themselves whether the President is right in saying that the road upon which Bismarck launched German medicine is the road down which free America ought to travel.

CONGRESSMAN RALPH W. GWINN,
27th District, New York

Westchester Medical Bulletin
(White Plains, N. Y.)

The School of Medicine of the University of Oklahoma is starting its first group of senior students through a new type of training. Each student will spend eleven weeks at some time during the year observing general medical practice in a small community.

The preceptors for this training are general practitioners who are appointed to the faculty of the school for this purpose. The students will observe and receive instruction in all phases of general practice, including office work, house calls and hospital rounds.

The program as outlined will increase the length of the senior year from thirty-two weeks to forty-four weeks. It is expected that education of this type will encourage young doctors to practice in the smaller communities.



President's Page



YOU SHOULD PLAN TO GO NOW

INDIANA has had many great medical meetings, but there will be but one Centennial in your time and mine.

Your State Medical Association has been planning and looking forward to this one event for several years and is rightfully determined to make this the greatest meeting in the one hundred years' history of Indiana Medicine, a state medical meeting second to none in these United States.

I need not make a special appeal to those who regularly attend the annual sessions of our Association, for they will be there. I do wish to remind the many good doctors in Indiana who seldom attend our state meetings that this is your Centennial, an historical celebration in honor of you and all the members of our Association. We expect you and especially invite you to attend.

YOU WON'T BE HERE FOR THE NEXT ONE

The committees responsible for this great celebration have arranged four exceptional days and nights of scientific program, talented entertainment, and sports events, for your enlightenment and enjoyment, including up-to-the-minute instructional courses, scientific lectures by an all-Hoosier staff of medical leaders from the great medical centers of America, television of surgery and clinical treatment direct from the Indiana University Medical Center, Scientific and Historical Exhibits that promise to exceed anything attempted by a state medical association, and the largest technical exhibit in the history of our Association. While all this is going on there will be a splendid program of interest and entertainment for the ladies.

I wish it might be possible for every physician in Indiana to attend all four days of the Centennial Celebration, but it is possible for every physician to attend at least a part of this great meeting. Indianapolis is within a few hours drive of every section of the state. The time of the year, September 26-27-28-29, is ideal for travel and conventioning, and is a healthy time for doctors to get away. Now that most counties in Indiana have adopted some plan of "around-the-clock" medical care, you will find it easier to plan your absence from duty, and your patients will not want for medical care while you are away.

Regardless of the day or hour you come, you will find a continuous program of events well worth your time and effort.

You will be thrilled by this great historical pageant of the one hundred years of progress in Indiana Medicine, and will go back to your office a better doctor, for you will have met and mingled with your professional colleagues, exchanged ideas on the many problems in the present crisis of American Medicine, and you will have seen and heard "What's New" in scientific medicine at the dawn of a new century.

When you go home tonight, talk this over with "Mom" and say:

"WE BETTER GO NOW: WE WON'T BE HERE FOR THE NEXT ONE."

Augustine P. Hauss

ORDER YOUR TICKETS FOR THE 1949 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1949 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Monday, September 26, 1949.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is \$1.00 per class with a maximum charge of \$3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

All Classrooms in Dining Room—On the Ground Floor						
Hour	Room A	Room B	Room C	Room D	Room E	Room F
11:00 A.M.	The Psychological Management of Patients Course 1	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 2	Ano-Rectal Conditions Course 3	Management of Common Gynecological Problems Course 4	Arthritis Course 5	Recent Developments in Antibiotic Therapy Course 6
NOON RECESS						
1:00 P.M.	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 7	The Management of Diabetes Mellitus Course 8	Diagnosis and Treatment of Common Skin Diseases Course 9	Infant Feeding Problems Course 10	The Problem of Obesity Course 11	Ear, Nose and Throat Emergencies Course 12
2:00 P.M.	The Demonstration of a Physical Diagnostic Examination Course 13	The Problems of Hypertension Course 14	Diagnosis and Treatment of Genito-Urinary Conditions in General Practice Course 15	Pediatrics in General Practice Course 16	The General Practitioner and Backache Course 17	Asthma, Hay Fever and Allergies in General Course 18
3:00 P.M.	Headache Course 19	The Management of the Menopause Syndrome Course 20	The Selection of Patients for Thoracic Surgery Course 21	Obstetrical Emergencies Course 22	Orthopedic Measures General Practitioners Can Use Course 23	What Can Neurological and Neurosurgical Treatment Offer Your Patient Course 24
4:00 P.M.	The Demonstration of a Diagnostic Neurological Examination Course 25	The Management of the Problems of the Elderly Course 26	The Management of Gastroenterology in General Practice Course 27	Impotence, Infertility and Maternal Health Service Course 28	A Lawyer Looks at Malpractice Suits Course 29	Diagnosis and Treatment of Common Skin Diseases Course 30

Cut on Dotted Line

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for \$1.00; \$2.00; \$3.00. Please reserve tickets for the following Instructional Courses:

First choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, September 26, 1949.

Signed:M.D.

Address:

FRANK BARBOUR WYNN*

Founder of Scientific Exhibit of the American Medical Association

WM. NILES WISHARD, JR., M.D.

INDIANAPOLIS

IN 1818 a vessel sailed from England bound for Norfolk, Virginia. The ship met with stormy seas and other adversities during which the captain lost his way. A passenger from Stolkley took over to help guide the way. After three turbulent months the boat reached its destination and the passenger, John Wynn, came to settle at Brookville, Indiana, where he became a teacher of mathematics, a bank cashier, a road builder and surveyor.¹ His son James was a scientific farmer and inventor. From such a grandfather and father it is not surprising to find the distinguished pathfinder whom we honor here tonight—Frank Barbour Wynn. He had the advantage of being born in the country near Brookville, Indiana, in Franklin County, on May 28, 1860. After preliminary education in the grammar and high schools, he received his A.B. degree from DePauw University in 1883, the M.D. from Miami Medical College (now Cincinnati Medical School) in 1885, and an A.M. in chemistry from DePauw in 1886. In the latter year he became an intern in Cincinnati's Good Samaritan Hospital. For five years he continued in general, medical, surgical, and insane hospital service. Like other embryo leaders of his day he devoted two years (1892 and 1893) in Vienna, Berlin, London and Paris to the study of internal medicine and pathology.²

Late in the fall of 1893 Doctor Wynn opened his office in Indianapolis. He became a teacher of pathology in the old Indiana Medical College, a position he held for ten years.¹ For fifteen years thereafter he held the chair of medicine in the Indiana University School of Medicine. He was the first city sanitarian of Indianapolis, in 1895 and 1896.

On June 25, 1895, he married Miss Carrie L. Arnold of Dayton, Ohio. She survived him only four years. Their son, Dr. James A. Wynn, a man like his father, of unusual brilliance, died in the early years of his medical career. The son's wife and daughter survive.

Doctor Wynn's interest was focused early on the struggle against venereal disease and tuberculosis. He was an ardent pathologist, advocating autopsies on all who died. He believed in the quarantine of all infectious syphilitics early in the campaign to place venereal disease before the public. He was a valued source of scientific information, upon whom our great Hoosier Health Officer, Dr. J. N. Hurty, leaned heavily.³

Pathology came into its own in the latter part of the 19th century. In 1897 the Indianapolis Medical Society was holding case history nights once a month, accompanied by the presentation of pathological specimens.⁴ Because of his interest in pathology it was only natural that Doctor Wynn was the impetus which made these affairs the success they were. By 1898 he had amassed a creditable exhibit. My father, who was president of the Indiana State Medical Society at the Lafayette meeting in 1898, requested Doctor Wynn to arrange his exhibit of pathology for presentation at the Indianapolis meeting the next year. This was such a success that a committee report was read by Dr. F. C. Heath on June 2, 1899, at the Fiftieth Anniversary of the State Association, requesting Doctor Wynn to take his pathological exhibit to the Columbus, Ohio, meeting of the American Medical Association on June 6-9, 1899, and authorized the appropriation of up to \$300.00 to defray expenses.⁵

"Among the most significant and important developments for the advancement of medical science has been the Scientific Exhibit,⁶ the most valuable effort in behalf of graduate medical education attempted by any organization anywhere in the world." Its function is graduate medical instruction.⁴ The Bureau of Exhibits began in 1899 and, according to Doctor Hull, "the Scientific Exhibit of the American Medical Association is the result of the initiative of two men, W. N. Wishard and Frank B. Wynn of Indianapolis."

Just how much the American Medical Association owed for its Scientific Exhibit to Hoosier pride and fear of provincialism we may learn from the discussion which followed the reading of Doctor Heath's resolution at the State Medical meeting in 1899.⁵ Objection was first raised that the matter had been put off until too late, (the A.M.A. meeting being only a week off) to spend so much money to take the exhibit to Columbus without proper publicity or place to house it. It was suggested by Dr. Edwin Walker of Evansville that the money be employed to develop the museum. It was further suggested by Dr. L. D. Brose that the College at Columbus would have exhibits and that unless ours had some preliminary publicity the doctors would be so engrossed with other sections that Indiana would not get sufficient credit to pay for the expenditure. Dr. A. W. Brayton demurred on the ground that a future meeting of the American Medical Association was to be hoped for in a few years in Indianapolis and he desired time for

* Paper read at Fiftieth Anniversary of the Scientific Exhibit, American Medical Association, Atlantic City, New Jersey, June 7, 1949.

the exhibit to grow so that Doctor Wynn could present it bigger and better at a later date when the association might come to Indiana. In the meantime the work of the local Scientific Exhibit could be advertised to the other states showing the original work being done in Indiana in preparation for a bang-up meeting in Indianapolis. He proposed that Doctor Wynn print the record of the specimens.

To all of which Dr. Wynn⁵ replied, "I have heard a number say that our eastern pathologic brethren have an idea that Indiana doctors don't know much about scientific medicine. Now we have come out of mossbackism in a literary sense. We have our Riley and our Wallace who have given us standing in a literary way, and there is no one thing that we can do at this time that will so elevate us in the estimation of the eastern profession or show what we have done in the past year or so. It will give us prestige. Now, suppose that we print the history of these specimens. Do you know what an immense amount of labor that means? And I know upon whom it would fall. I think this collection should be taken to Columbus, and believe we will get immediate benefit from the plan the Committee recommends."

Dr. A. E. Sterne seconded Doctor Wynn's remarks, as did Dr. Theodore Potter, though the latter did not see how it would be possible to spend as much as \$300.00 in one year on the Scientific Exhibit, thinking that \$25.00 or \$50.00 would ship the material to Columbus. He said that now is the time to send the exhibit and not wait for some hypothetical future meeting of the American Medical Association at Indianapolis. Fortunate indeed, for the meeting never came.

To a rising vote of 18 ayes and 7 noes at that Fiftieth Anniversary meeting of the Indiana State Medical Society the American Medical Association owes the birth of its Scientific Exhibit. There had been nothing like it before. Doctor Wynn took it to a warehouse, rented across from the State Capitol building. Over 700 specimens were exhibited, accompanied by demonstrations. Much of the expense my father bore personally.⁴ The exhibit was well received and bore favorable comment. Dr. C. E. Slocum⁶ of Defiance, Ohio, introduced a resolution commending the efforts of the Indiana State Medical Society in preserving pathologic specimens and exhibiting them at the Columbus meeting. Doctor Wynn urged a similar exhibit for each future meeting of the American Medical Association, and the establishment of a section on pathology. At the 1900 meeting in Atlantic City a special committee was appointed to look after the Scientific Exhibit. Dr. Joseph Stokes of Morristown was chairman and Doctor Wynn secretary. In 1902 Doctor Wynn was chairman of the section on Pathology and Bacteriology. He outlined policies which are, a half century later, still practical, and urged that the exhibits be kept free of commercialism. During its first few years⁴

the Scientific Exhibit was the "handmaid" of the Section on Pathology. Doctor Wynn was the moving spirit, acting director of the Scientific Exhibit, and chairman of that committee until 1916. At the Boston meeting in 1906⁶ the Board of Trustees presented him with a loving cup for his many efforts.

Doctor Wynn had all the attributes of an educated, cultured, Christian gentleman. His hobbies were nature study and mountain climbing. His outstanding abilities led him to be elected president of most of the associations to which he belonged. In this capacity he served the Indiana State Medical Association in 1914-1915, the Indianapolis Medical Society 1908,⁷ the Nature Study Club of Indiana (1920-1922), American Alpine Club (1922), Indiana Centennial Commission (1911-1916), Mississippi Valley Medical Association (1920), Lincoln Memorial Association, and first vice-president of the American Medical Association in 1921. He was active in the Indiana Historical Society, (one time president), and historian of the Methodist Congregation of Indianapolis. He was a member of the House of Delegates of the American Medical Association in 1913-1914. DePauw gave him an Sc.D. in 1922.

Doctor Wynn was an expert, experienced and conservative mountain climber. As in other fields, his activities led him to summits all over the world. The engraved silver plate adorning the handle of his ice ax² bore the names of many mountains he ascended, including the Jungfrau and Mount Blanc. In America he climbed all the important peaks, both east and west. His special fondness was for Glacier Park, Montana, many of whose mountains he was first to ascend. The writer had the privilege of being a member of his 1921 expedition, The Terramas, when Mount Reynolds in Glacier Park was first climbed. In that year a protracted but unsuccessful attempt was made to reach the unscaled peak of Mount Wilbur. At about the same time Doctor Stone, president of Purdue University and long time friend of Doctor Wynn, was killed in the Canadian Rockies. When not actually climbing on some mountainside, Doctor Wynn was always assured of an interested audience in the hotels of Glacier Park, who listened to his lectures on mountain climbing, in which he frequently got in a word of eulogy for this sport in promoting health.

In the summer of 1922 the party was back in Glacier Park to make a more serious attempt to climb Mount Wilbur successfully. The summit of this mountain is guarded by almost perpendicular 700-foot walls at the top. On July 26, 1922, Doctor Wynn started off from Many Glacier Hotel with Dr. H. H. Goddard, Director of the Bureau of Juvenile Research of Ohio (formerly of Vineland, New Jersey). They climbed up into Peigan Pass where they camped for the night on a conditioning expedition preliminary to the proposed attempt on Mount Wilbur. At 5:30 A.M. on the morning of

July 27, 1922, they left the Pass and started up the side of Mount Siyeh. Later on the same morning, as I left the hotel, I was astonished to find Doctor Goddard returning down the trail so early in the day. My inquiry of surprise was met with the reply, "Bill, Doctor Wynn is dead." They had come to a large boulder six or eight feet high and in deciding whether to go around or over, Doctor Wynn had remarked "I don't know which way to go." He essayed the latter course, and when almost to the top of the boulder, without outcry or alarm, fell backward over Doctor Goddard who was below him, and rolled down a shale slide some 300 feet. Doctor Goddard rushed down and found him dead. He was of the opinion that Doctor Wynn had had an apoplexy which caused the fall, for the climb was not difficult for one as experienced as Doctor Wynn.

My brother and I at once started out by horse from Many Glacier to meet a rescue party of park rangers starting out from Going-to-the-Sun Camp. Our parties met at about the same time on the trail below the point where Doctor Wynn lay. His body was carried down the mountainside to a waiting horse. The cavalcade then proceeded down the trail to Going-to-the-Sun Camp where we arrived before sundown. Then followed an interview with the Park Director. After dark Doctor Wynn was placed in a rowboat with outboard motor, and, piloted by a ranger, we crossed St. Marys Lake to St. Marys Chalet where there was a motor road connection to the Great Northern Railroad at Glacier Park Station. He was buried August 1, 1922, with many tributes from the press and the profession.

During World War I Doctor Wynn repeatedly tried to get into active service but was refused because of his age.² This was a bitter disappointment. As an alternative he spent a number of months in the Surgeon-General's office in Washington, serving as a "dollar-a-year" man. Having also been an esteemed member of the State Conservation Commission, that organization gave him the following tribute: "Multis Ille Bonis Flebilis Occidit. Not to lament the dead or solace grief with empty hands, but to acknowledge the commonwealth's vast debt to one of her foremost sons who, clinging to his state with all the fibres of a

pure heart and a lofty mind, representing by tradition and inheritance the best of a great formative past, brought health, happiness and understanding through the skill of his profession and the magic of his soul to those he knew and loved best, the men, women and children of his own Indiana, we register mournfully the irreparable loss of a collaborator, a counselor and a friend."

In addition to his many scientific papers Doctor Wynn also found time to write on nontechnical subjects. During the last few years of his life he wrote a series of twenty-one articles in *The Journal of the Indiana State Medical Association* on "The Physician." These exemplified his broad humanitarianism and deep religious convictions. The last of these articles,⁸ published only three months before his death, was on "The Physician—How May He Grow Old Gracefully?" In it he remarked, "the physician who would grow old gracefully must begin early. . . . In the journey toward life's end his paths will be those of peace and his rewards those of the just." He closed this last of his published papers with the quotation from Ecclesiasticus XXXVIII:3 "The skill of the physician shall lift up his head and in the sight of great men he shall be praised." Truly he was prophesying the esteem with which he was and would be held by his colleagues, though he wist not that he did.

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AMERICAN MEDICAL ASSOCIATION 98TH ANNUAL SESSION

ATLANTIC CITY, JUNE 6 TO 11, 1949

THE 1949 Annual Session of the A.M.A. was conducted with the second largest registration in the history of the Association. Attendance was exceeded only by the 1947 Centennial Celebration. There were 13,221 doctors registered for the five-day program. Total registration was swelled to 31,552 by the enrollment of 14,671 guests, including wives, residents, interns, nurses and technicians, and 3,660 exhibitors.

Physicians were present, not only from all parts of the United States, but also from particularly every civilized country in the world, to participate in the clinical program and to view the scientific and technical exhibits.

The assembly itself was preceded by meetings of a score or more of specialty societies. Also, on Sunday, June 5, the "Grass Roots Conference" of County Medical Society Officers met under the chairmanship of Dr. A. M. Mitchell of Terre Haute. The Conference of Presidents and Other Officers of State Medical Associations met on Sunday afternoon.

The Woman's Auxiliary to the American Medical Association met during the convention, with numerous business sessions and several social events for the visiting ladies.

The session was of particular interest to Hoosiers. Dr. Roscoe L. Sensenich of South Bend completed a busy and fruitful year as president and received a medal as retiring president from the hand of Dr. Elmer L. Henderson, chairman of the Board of Trustees.

Another Hoosier to be signally honored was the founder of the Scientific Exhibit, Dr. Frank B. Wynn. The Exhibit in celebrating its own 50th anniversary was planned especially to honor Doctor Wynn, and an address was read as a tribute to his memory at the Inaugural Meeting, by Dr. William N. Wishard, Jr., of Indianapolis.

SCIENTIFIC ASSEMBLY

The general scientific meetings were highlighted by a symposium on advances in medicine, arranged by Drs. Roger I. Lee and Frank H. Lahey of Boston. The morning program on Tuesday was devoted to Modern Developments in Surgery, with papers by Drs. Alfred Blalock, Richard Sweet, Frederick Collier, Champ Lyons, and Ralph Tovell, with a summary by Doctor Lahey. The afternoon program discussed Modern Developments in Medicine, with contributions by Drs. Perrin H. Long, Charles Huggins, John H. Lawrence, Frederick Stare and C. J. Watson, with a summary by Doctor Lee.

Most of the 18 Sections held three meetings, with full programs of papers presented on the widest possible variety of subjects.

Drs. V. K. Stoelting and J. P. Graf of Indianapolis read a paper on "Dimethyl Ether of d-Tubocurarine Iodide as an Adjunct to Anesthesia" before the Section on Anesthesiology.

Dr. Sprague H. Gardiner, of Indianapolis, discussed a paper by Dr. Duncan E. Reid, of Boston, who talked before the Section on Obstetrics and Gynecology. The paper was on "Evaluation of Present Day Trends Pertaining to Personality and Psychologic Aspects of Pregnancy." Another paper presented at this section, on "The Conservative Treatment of Premature Separation of the Normally Implanted Placenta," by Drs. John R. McClain and Samuel R. Poliakoff, both of Atlanta, was discussed by Dr. C. O. McCormick, of Indianapolis.

In the Section on Laryngology, Otology and Rhinology, Dr. Ralph J. McQuiston, of Indianapolis, was an invited discussant of a paper on "Diagnosis and Treatment of Tumors of the Neck," by Dr. D. F. Weaver, of Detroit.

Dr. S. R. Mercer, of Fort Wayne, opened the discussion on a paper on "Misplaced Mongolian Spot," by Dr. H. N. Cole, Jr., of Cleveland, and Dr. W. R. Hubler, of Corpus Christi, which was presented before the Section on Dermatology and Syphilology.

Dr. Carroll C. Hyde, of South Bend, opened the discussion on a paper on "Excretory Urography Versus Retrograde Urography: Their Respective Advantages and Indications, with Illustrated Cases," by Drs. J. Byron Beare and Carl A. Wattenberg, of St. Louis, and on a paper on "Significant Scrotal Swellings," by Dr. R. Theodore Bergman, of Los Angeles. These papers were presented at the Section on Urology. At this same section, Dr. Ernest Rupel, of Indianapolis, opened the discussion on the following papers: "Analysis of the Treatment of Bladder Tumors," by Drs. W. Calhoun Stirling and J. E. Ash, Washington, D. C.; "Papillomata of the Bladder," by Drs. Herman L. Kretschmer and Edward A. Stika, Chicago; and "Vesical Neoplasms of the Female Bladder: A Suggested Surgical Technic," by Dr. J. Sydney Ritter, of New York.

GOLDEN ANNIVERSARY OF THE SCIENTIFIC EXHIBIT

The Scientific Exhibit this year contained a special group of exhibits to commemorate the

founding of the Exhibit in 1899, and to honor its founder, Dr. Frank B. Wynn.

A special historical exhibit which dealt with the life and activities of Doctor Wynn was prepared for the Indiana State Medical Association and Indiana University School of Medicine, by a committee consisting of Dr. Thurman B. Rice, chairman, Dr. J. O. Ritchey, and Dr. E. V. Hahn, all of Indianapolis. This exhibit attracted a large number of visitors and created much interest in the origin and development of the Scientific Exhibit.

A special clinical laboratory exhibit was prepared by a committee from Philadelphia. Seven individual exhibits were prepared to illustrate the advances in pathology which have occurred during the past 50 years.

The main part of the exhibit was, as usual, the outstanding feature of the entire convention. It was termed by many observers as worthy of several days study, and by itself was justification enough for the convention trip. It was a splendid tribute to its founder.

The special exhibit on the treatment of fractures presented continuous demonstrations for five hours each day in each of six booths, each one of which was devoted to a single fracture problem.

Three exhibit symposiums were included. These dealt with diabetes (4 exhibits) arthritis (12 exhibits), and physical medicine and rehabilitation (10 exhibits).

The American Diabetes Society conducted a four-day series of clinics and conferences in connection with their exhibit symposium. Lectures on laboratory methods were given to supplement the demonstrations on clinical laboratory methods given in the exhibit booths.

Each of the 18 sections of the Assembly and the U. S. Army and U. S. Navy presented groups of exhibits.

COLOR TELEVISION

The thousands attending the convention were privileged to witness the first major demonstration of color television. Surgical operations and medical clinics conducted at the Atlantic City Hospital were televised and transmitted by radio to Convention Hall. There the program was viewed on multiple color receivers.

Black and white television has offered many advantages to the surgical technique phase of medical education by being able to produce multiple images of operative procedures viewed from the most advantageous spot in the operating room. Color television demonstrated that the natural colors of the operative field could be reproduced on the screen with remarkable fidelity.

Surgical and medical clinics were televised from 9 a.m. to 5 p.m. during all four days of the meeting and played to SRO audiences most of the time.

The equipment was manufactured by the Columbia Broadcasting System especially for medical teaching. It is owned by Smith, Kline and

French, and will be used by them for similar demonstrations in the future.

TELEVISION INTERPRETATION OF X-RAYS

Aids in the interpretation of x-ray films by use of the television camera and receiver were demonstrated by the University of Illinois College of Medicine, in cooperation with the Radio Corporation of America and E. R. Squibb and Sons.

Investigation at the University of Illinois on the feasibility of transmission of x-ray films by television has demonstrated advantages in interpretation which may become of greater importance than the ability to transmit the film itself.

The contrast range of a film may be varied by adjustments which are easily made in the televising apparatus. The image which is seen on the television screen may be changed through the entire range of contrast from very soft to very hard as easily as a microscope is changed in focus.

By use of the contrast change, details of soft tissue, questionable shadows, and correction of over- and under-exposure were demonstrated. By varying the contrast a single film may be used to show soft tissue changes or bony detail.

The value of transmitting films for consultation is considerable, but the ability to study a single film through all ranges of contrast may easily prove to be the most valuable result of this study.

AMERICAN PHYSICIANS ART ASSOCIATION

The eleventh annual exhibition of the APAA as sponsored by Mead Johnson and Company was held in conjunction with the meeting.

Entries this year were limited to two by each physician. This resulted in a smaller show, but contributed a great deal toward its quality. The exhibit was housed in the Convention Hall. The relatively small number of entries greatly facilitated the arrangement and display of the individual pieces. The 700 odd entries were viewed by a large and appreciative assemblage which crowded the space at all times.

Indiana was represented by Dr. Beaumont S. Cornell, of Huntington, who exhibited an oil painting; by Dr. Dwight L. DeWees of Indianapolis, with two oils; and by Dr. Walter A. Dycus of Evansville, with two photographs. One of Doctor Dycus' entries, entitled "Leavenworth Overlook," was awarded an Award of Merit with the APAA Medal and Certificate. Doctor Cornell's painting received an Award of Merit with the APAA Medal and Certificate.

THE "GRASS ROOTS" CONFERENCE

One of the most beneficial meetings held prior to the opening of the annual A.M.A. convention at Atlantic City was the National Conference of County Medical Society Officers, better known as the "Grass Roots" conference, for the discussion of problems at the county society level.

Dr. A. M. Mitchell of Terre Haute served for the third year as chairman of this fine conference and was re-elected.

Subjects discussed were varied. The discussion of plans for handling emergency calls attracted the most interest, but talks also included indigent medical care plans and methods of handling the A.M.A.'s national education campaign.

Headline speakers at the conference were Clem Whitaker of Whitaker & Baxter, and U. S. Senator John L. McClellan of Camden, Arkansas.

CONFERENCE OF PRESIDENTS

ATLANTIC CITY, JUNE 5, 1949

THE Conference of Presidents and Other Officers of State Medical Associations met immediately prior to the A.M.A. meeting, on Sunday, June 5. Dr. Joseph H. Howard of Bridgeport, Connecticut, presided.

William Alan Richardson, Editor of *Medical Economics*, reported on his personal observations of the British National Health Service. He stated that the cost for the first year of operation is expected to be close to 1.5 billion dollars, and that the burden for the second year would probably be 2.5 billion dollars. These figures do not include capital expenditures which are planned for the future, and which are estimated at 1.5 billion dollars each for building hospitals and health centers.

In industrial centers of England he said that many physicians have lists of patients as large as 4,000. The average number of visits per year will be slightly over six. For such a list the doctor will, at a conservative estimate, make 24,000 visits per annum, or about 80 visits per working day.

In sparsely settled districts, where the physician spends more time traveling, the lists are smaller. However, Mr. Richardson says British doctors find themselves usually with too large a list, to which they cannot render proper medical care, or with a small list which they can care for by hard work, but which, on the present capitation fee, will not provide them with a living salary.

Patients are beginning to realize that they are missing the personal touch of private practice. Doctors are so overworked that some of them are prescribing without examining the patients, and even at times without seeing the patient.

Britishers who are in favor of the system answer the above facts by pointing out that there are no more patients than there were formerly. Mr. Richardson stated that this is perfectly true, but what is not generally recognized is that the same number of patients has created an overwhelming amount of work for the medical profession, by a greatly increased number of visits, many of them unnecessary.

Dr. Clarence E. Northcutt of Ponca City, Oklahoma, spoke of the need for changes in the economic aspects of medical care. He recommended

that the economic ills be cured by adoption of voluntary medical insurance. He pointed out that, while the present campaign was arduous and would continue to be so for some time, the medical profession, if successful, might be accorded the credit for reversing the present, almost universal trend toward socialism.

Doctor Northcutt had three suggestions for improvement of medical public relations:

1. Training of lay medical office assistants in habits of courtesy and sympathy.
2. Continuing and expanding the present program for participation by women's medical auxiliary organizations.
3. Establishing a grievance committee for each medical society for the purpose of receiving and investigating complaints against doctors.

Cecil Palmer of London, England, publisher, author, journalist, and signatory of the famous "Manifesto on British Liberty" delivered a stirring address on "The Impact of Socialized Medicine on the British Physician and His Patient."

He described two main effects on the National Health Service. The first is that it has revolutionized the status of the doctor by making him a servant of the state.

The other effect is the destruction of the doctor-patient relationship.

He also said that, despite solemn promises made prior to enactment of the law, confidential records of diagnosis and treatment are now open to the local lay councils.

Mr. Palmer reported that, even though overworked, many doctors are not able to make a living and that some are borrowing money for current expenses. The total cost of NHS is so high there is no prospect of increasing the capitation fee. Some hospitals have already been instructed to operate on lower budgets.

The conference was concluded by a discussion of state compulsory disability compensation programs. These programs are in effect in three states at present, and will soon be in effect in a fourth state. They pay compensation for nonoccupational accident and disease.

Mr. Edward H. O'Connor of the Insurance Economics Society of America described the plans as originating with a purpose of utilizing excessively large unemployment insurance reserves. Some states permit the participation of private insurance carriers, which are operated more economically than are the state plans. He expressed concern as to the possibility of extension of the state programs with elimination of the private companies.

Mr. O'Connor felt that hospital benefits and comprehensive health insurance might also be added to the plans in the future.

Dr. Bert S. Thomas, Medical Director, Department of Employment, State of California, described

the medical administrative problems of such a program. He stated that cooperation of the medical profession is essential to an equitable and just administration of benefits. He described the methods of checks which are necessary in order to control malingering and chiseling, which he said have been held to a minimum.

Dr. Clarence E. Northcutt, Ponca City, Oklahoma, past president of the Oklahoma State Medical Association will serve as president of the con-

ference during the coming year. Dr. Julian Price, of Florence, South Carolina, secretary of the medical society there, was named president-elect. John E. Farrell, of Providence, Rhode Island, executive secretary of the Rhode Island Medical Society, was re-elected secretary-treasurer.

Elected as members of the executive committee were Dr. Joseph Howard, Bridgeport, Connecticut; Dr. Andrew S. Brunk, Detroit; and Dr. Ross Wright, Tacoma, Washington.

A.M.A. WILL CALL NATIONAL CONFERENCE TO STUDY PROBLEMS OF MEDICAL CARE

HOMER G. HAMER, M.D.*

INDIANAPOLIS

STEPS leading to the solution of medical care problems "the voluntary way" were taken by the House of Delegates of the American Medical Association at Atlantic City in June, when it authorized the calling of a national health conference, probably at Chicago, in late summer or early fall.

The purpose of the conference is to sound out labor, farm and business groups, and even members of Congress on the A.M.A.'s own 12-point program for voluntary insurance and public health improvement. Some farm cooperatives and labor groups have been approached by the Council on Medical Service of the A.M.A., with the idea of finding a formula for making medical services available for all the people without government control of patients and physicians.

This conference is a new line of attack against President Truman's compulsory health insurance plan—a positive approach—by offering a health plan devoid of government medicine evils which are so revolting to the profession. The friends of medicine in Congress want a health program acceptable to the doctors, and one also workable and satisfactory to the people.

The 12-point program was elaborated on by the A.M.A. Board of Trustees. (It was published in full in the July JOURNAL.) The 12 points call for such things as setting up a federal department of health, headed by a physician, to integrate all federal health activities, and the distribution of health funds at state and local levels. The A.M.A. supports extension of voluntary hospitalization and medical insurance plans, including nonprofit, commercial and industrial plans. In reiterating a call for establishment of "complete public health cov-

erage for the country with federal aid," the Board of Trustees said:

"Large areas of the country are without proper public health service and many of these areas cannot afford such service. Prevention of disease at the source will decrease the need for medical care."

SILENCING OF DOCTOR FISHBEIN

The first big news to come out of Atlantic City was the action of the Board of Trustees in muzzling Dr. Morris Fishbein, editor of the A.M.A. Journal. Following is the statement read to the delegates by Dr. Elmer Henderson of Louisville, Kentucky, chairman of the board:

"The Board of Trustees is aware of the criticism of the Editor coming from within and from without the profession. The Board recognizes that the public has come to believe that the Editor is the spokesman of the Association. The membership undoubtedly wishes the elected officials to speak authoritatively on all matters of medical policy.

"Against the time when the Editor retires, Dr. Austin Smith has for some months been in training as the Assistant Editor and the talent of the Editor will be retained for the present under the control of the Board of Trustees.

"In view of the increasing responsibility of the Editor and reorganization of the department, the Board of Trustees has decided on the following points:

"1. The Editor will completely eliminate speaking on all controversial subjects both by platform and by radio. Approval of all speaking engagements will be made by the Executive Committee.

"2. Elimination of all interviews, including press conferences and statements, by Doctor Fishbein, except on scientific subjects.

* Delegate from the Indiana State Medical Association to the House of Delegates of the American Medical Association.

"3. Editorials on controversial subjects will be supervised by the Executive Committee.

"4. Complete information as to these activities will be reported to the members of the House of Delegates.

"5. There will be permanent elimination of diary in Tonics and Sedatives.

"6. Plans for the training of a new Editor in an orderly manner, including the retirement of the present Editor, will be formulated.

"The Board of Trustees of the American Medical Association announces that plans have been formulated for the retirement of Dr. Morris Fishbein as Editor of *The Journal of the American Medical Association* at an appropriate time. For thirty-seven years Dr. Fishbein has served the A.M.A. well and faithfully. *The Journal of the A.M.A.* is an enduring monument to his genius and devotion. His activities have extended far beyond his immediate duties as an Editor and the Board desires to pay tribute to his many accomplishments in other fields.

"The Board finds that serious dislocation would result from any sudden replacement. With this in mind, a reorganization of the editorial staff is underway so that his retirement, when consummated, will not result unfavorably for ventures of the Association."

The day after the statement was read, the delegates gave a vote of confidence to the Board of Trustees. That was the end of the subject, officially at least.

O.K. GIVEN "CO-OP" HEALTH PLANS

The delegates gave approval to any voluntary health insurance plan, nonprofit, cooperative or commercial, providing the plan is sanctioned first by any county or state medical society and also meets a set of twenty principles developed by the Council on Medical Service. Heretofore the A.M.A. has recognized only these medical care plans sponsored by its federated county and state groups. The new policy makes it possible for numerous plans operated by labor, farmer, consumer cooperative and other groups, including city governments, to win approval.

OTHER HOUSE OF DELEGATES ACTION

Additional actions by the delegates follow:

1. Authorized change in by-laws creating a Section on Physical Medicine and Rehabilitation.
2. Defeated a recommendation that the A.M.A. establish annual dues.
3. Authorized by-law change to give the Air Force representation in the House of Delegates along with Army, Navy, Veterans Administration and United States Public Health.
4. Added two more to Committee on Scientific Assembly, one of whom must be a general practitioner.
5. Voted down a suggestion that selection of "Family Doctor of the Year" be discontinued.

6. Approved passage of state laws restricting making birth records available only to certain specified individuals.

7. Urged leaders of the A.M.A., state and county medical societies to "use their influence" to get county medical societies to support financially the collection of the assessment to finance the national educational campaign against socialized medicine.

8. Approved development of an enrollment agency to procure national accounts for Blue Shield plans.

9. Defeated a recommended change in method of the Veterans Administration in handling hospital and medical care of veterans for nonservice-connected disabilities.

10. Gave the 1949 Distinguished Service Award to Dr. Seale Harris of Birmingham, Alabama.

11. Approved separation of the Associated Medical Care Plans from the American Medical Association.

12. Recommended establishing of two-year rotating internships for general practitioners.

Dr. Elmer L. Henderson of Louisville, Kentucky, was unanimously elected president-elect. Dr. Henderson will assume the presidency at the annual meeting in San Francisco in June of 1950. Dr. Ernest E. Irons of Chicago assumed the presidency at Atlantic City.

Dr. James Francis Norton of Jersey City, president of the Medical Society of New Jersey, was elected vice-president. He succeeds Dr. Roy W. Fouts of Omaha.

Dr. George F. Lull of Chicago was reelected secretary; Dr. Josiah J. Moore of Chicago, reelected treasurer; Dr. Frank F. Borzell of Philadelphia, reelected speaker of the House of Delegates, the policy-making body of the Association, and Dr. James R. Reuling of Bayside, New York, reelected vice speaker.

Dr. Louis H. Bauer of Hempstead, New York, was re-elected a trustee for five years and Dr. F. J. L. Blasingame of Wharton, Texas, was elected a trustee for a five-year term to succeed Doctor Henderson. Doctor Bauer was appointed chairman of the Board.

Chicago was selected as the convention city for 1952. Atlantic City was previously chosen as the 1951 meeting place. The meeting in San Francisco will be held June 26-30, 1950.

Denver, Colorado, was selected for the meeting place for the interim session late in 1950. Houston will be the interim meeting city in 1951 if facilities are made available by that time. The next interim meeting will be in Washington, December 5-9, 1949.

Indiana was represented in the house of delegates by four delegates—Dr. William Cockrum of Evansville; Dr. E. S. Jones of Hammond, alternate for Dr. A. S. Giordano of South Bend; Dr. A. M. Mitchell of Terre Haute, alternate for Dr. F. S. Crockett; and Dr. Homer G. Hamer of Indianapolis. Doctor Hamer was on the Medical Education Reference Committee.

The following Indiana physicians registered at Atlantic City:

Allen, H. E., Richmond
 Alvey, Charles R., Muncie
 Arbogast, J. L., Indianapolis
 Bartley, Max D., Indianapolis
 Baxter, Neal E., Bloomington
 Beeler, Raymond C., Indianapolis
 Bergan, Joseph A., East Chicago
 Bibler, Lester D., Indianapolis
 Bishop, Charles Allan, South Bend
 Borders, Theodore R., Fort Wayne
 Bowers, J. W., Fort Wayne
 Brady, Samuel J., Gary
 Buckley, Ernest P., Jeffersonville
 Burnikel, Ray H., Evansville
 Cameron, Don F., Fort Wayne
 Campbell, John A., Indianapolis
 Casey, Stanley M., Huntington
 Cassady, J. V., South Bend
 Catlett, Marshall B., Fort Wayne
 Chen, K. K., Indianapolis
 Cockrum, William M., Evansville
 Conklin, Raymond L., Elkhart
 Conway, Glenn, Indianapolis
 Cook, George M., Hammond
 Cortese, Thomas A., Indianapolis
 Crandall, L. A., Jr., Elkhart
 Crimm, Paul D., Evansville
 Culbertson, Carl S., South Bend
 Cullnane, C. W., Evansville
 Dalton, John Eric, Indianapolis
 Donato, Albert M., Indianapolis
 Dugan, Thomas J., Indianapolis
 Dunning, Lehman M., Indianapolis
 Durkee, Melvin S., Evansville
 Edlavitch, B. M., Fort Wayne
 Eisaman, Jack L., Bluffton
 Engeler, James E., Lafayette
 Ewing, Nathaniel D., Vincennes
 Faussett, C. Basil, Indianapolis
 Fish, C. M., South Bend
 Fitzsimmons, E. L., Evansville
 Frankowski, Clementine E., Whiting
 Gaddy, E. T., Indianapolis
 Gardiner, Sprague H., Indianapolis
 Gastineau, Frank M., Indianapolis
 Gery, Richard E., Lafayette
 Graf, John P., Indianapolis
 Green, George F., South Bend
 Griep, Arthur H., Evansville
 Gustaitus, John W., East Chicago
 Hamer, H. G., Indianapolis
 Harris, Paul N., Indianapolis
 Hartley, C. A., Jr., Evansville
 Hattendorf, A. P., Fort Wayne
 Hauss, Augustus P., New Albany
 Herzer, C. C., Evansville
 Hines, Don Carlos, Indianapolis
 Hoffman, Arthur F., Fort Wayne
 Hull, Arthur W., Elkhart
 Hurley, Anson G., Muncie
 Irely, Paul Raymond, Plymouth
 Iske, Paul G., Indianapolis
 Jones, Eli Sherman, Hammond
 Kahan, Harry L., Gary
 Katterjohn, James C., Indianapolis
 Kelly, Wendell C., Anderson
 Kirtley, W. R., Indianapolis
 Kruse, Edward H., Fort Wayne
 LaFollette, Forrest R., Whiting
 Lang, Joseph E., South Bend
 Lehmberg, Otto F. C., Columbia City
 Levi, Leon, Indianapolis
 Liss, Emanuel C., South Bend
 McCaskey, C. H., Indianapolis
 McCormick, C. O., Indianapolis
 McDonald, R. M., South Bend
 McQuiston, R. J., Indianapolis
 Martin, Hugh E., Indianapolis
 Masters, Robert J., Indianapolis
 Megenhardt, Dennis S., Indianapolis
 Mercer, S. R., Fort Wayne
 Middleton, Harvey N., Indianapolis
 Miller, Richard C., Shelbyville
 Miller, Samuel T., Elkhart
 Mino, Victor H., Evansville
 Mitchell, Albert M., Terre Haute
 Montgomery, Lall G., Muncie
 Morrison, W. R., Kokomo
 Nafe, Cleon A., Indianapolis
 Neukamp, Frank H., Connorsville
 Newcomb, William K., Royal Center
 Norman, Olin B., Indianapolis
 Norman, William H., Indianapolis
 O'Rourke, Carroll, Fort Wayne
 Orr, W. Robert, Mishawaka
 Otten, Ralph Edward, Darlington
 Pace, J. V., New Albany
 Parker, John T., Gary
 Pitkin, Edward M., Martinsville
 Portteus, Walter L., Franklin
 Ramsey, Frank B., Indianapolis
 Rice, Thurman B., Indianapolis
 Ritteman, George W., Columbus
 Roach, C. E., Indianapolis
 Rosenbaum, David, Indianapolis
 Rosenheimer, George M., South Bend
 Ruddell, K. R., Indianapolis
 Rupel, Ernest, Indianapolis
 Ryan, W. J., Fort Wayne
 Sahlmann, Hans, Fort Wayne
 Schlesinger, Jacob, Hammond
 Scott, Frank M., South Bend
 Sensenich, R. L., South Bend
 Shafer, Marion R., Indianapolis
 Shellhouse, Michael, Gary
 Shumacker, H. B., Bloomington
 Snively, W. D., Jr., Evansville
 Stangle, W. J., Bloomington
 Stayton, Chester A., Indianapolis
 Steffen, J. T., Wabash
 Stern, S. Lewis, Hammond
 Stimson, H. R., Gary
 Stoelting, V. K., Indianapolis
 Stoycoff, Christ M., Gary
 Stygall, James H., Indianapolis
 Tennant, David L., Fort Wayne
 Tether, J. E., Indianapolis
 Thompson, John V., Indianapolis
 Tirman, Wallace S., Bluffton
 Unger, Abraham, Indianapolis
 Van Bokkelen, R. W., Mooresville
 Van Tassel, Charles J., Indianapolis
 Vore, Hugh A., East Chicago
 Weigand, C. G., Indianapolis
 Weiss, H. G., Evansville
 Weyerbacher, A. F., Indianapolis
 Wilson, Fred L., Terre Haute
 Wise, Charles, Camden
 Wishard, William N., Jr., Indianapolis
 Witham, Robert L., Culver

NATIONAL HEALTH INSURANCE BILL

Analysis of Senate Bill 1679 and H. R. 4312 and H. R. 4313

WRAY E. FLEMING*

INDIANAPOLIS

DURING a conference of newspaper publishers, the majority of whom expressed disapproval of a compulsory National Health Insurance program as provided by S. B. 1679 and H. R. 4312 and H. R. 4313, attention was directed to the fact that with all the material being distributed by proponents and opponents of the program, so little is really known by the general public about the subject.

As far as the public is concerned it only knows that administration spokesmen claim compulsory health insurance is not "Socialized Medicine" but that the medical, dental and nursing professions claim the operation of a compulsory health insurance program does constitute "Socialized Medicine." The result is a highly confused public caught in the middle of a battle of words, charges and counter-charges, all of which add to the confusion.

Despite the fact that well over a million dollars is being spent by the doctors in combating the trend toward so-called socialization of health and medical care, there is strong indication that the administration has a stronger position with the people through its political influence and its use of sympathetic terms in describing the alleged needs for such a program. The physicians, the dentists, the nurses and the hospitals are not reaching the man on the street with their propaganda concerning socialized medicine because the man on the street apparently no longer cares whether that once revered monument of freedom established by the Constitution is chipped off a little here and a little there. About the only part of the word "freedom" that means anything today is the first syllable, and if the administration can rely on that factor in convincing the people that the health insurance program will insure free medicine, free dentistry, free nursing and free hospitalization, people will find it easy to ignore its compulsory taxation provisions and socialistic aspects. After a decade and a half during which government bureaus have been thinking for the people and regulating the lives and the habits of the people, is it possible that the people would resent the loss of another freedom, particularly if they do not have an understanding of the proposed health insurance program and are only informed in generalities?

The purpose of this analysis of S. B. 1679 and H. R. 4312 and H. R. 4313 is to provide the information which the people deserve to have on that

'HEALTH' BILL IS MISNAMED

In an able and impartial analysis of the National Health Insurance and Public Health Act (the administration's bill), Wray E. Fleming, general counsel for the Hoosier State Press Association, finds that the measure would cost the average wage earner enormously, that it would not insure adequate medical care, that it is truly socialistic and that it is inimical to state sovereignty.

Mr. Fleming's most interesting observation, however, is that the bill is misnamed. He points out that the provisions affecting public health conditions would in the main be expansion of existing operations. The nub of the bill is the provision setting up tax-paid medical care. Therefore, Mr. Fleming writes, the bill should be called "the National Public Medical, Dental, Nursing and Hospital Act."

Proponents of the socialistic Truman measure would have us believe that professional medical care is the chief answer to higher national health standards. That way they seek to justify a law which inevitably would bring the medical and dental professions under state control. But, as Mr. Fleming notes, medical care is "a haven of last refuge to which people turn when good health has deteriorated." The average person seldom visits a doctor except for a periodic checkup. Proper food, moderate habits, adequate rest and good sanitary measures are the most important factors in his continuing good health.

As Mr. Fleming observes, the Truman bill appears to be a matter of "locking the barn door after the horse is stolen." The best name for the measure is "the National Socialized Medicine Act." Its proponents are guilty of misrepresentation when they offer it as a "health" bill.

Indianapolis Star, June 27, 1949.

widespread proposal. Any approach to the solution of the problem should be from the standpoint of individuals as Americans and not from the viewpoint of politicians, physicians, dentists, nurses or hospitals, all of whom are affected by the proposal. After all, it is Americans and the American way of life that will be most vitally affected in the years ahead. With that in mind, the following questions will be discussed in the series of articles directed to the contents of S. B. 1679 and H. R. 4312 and H. R. 4313.

What does the bill provide?

What will it cost?

Does it insure adequate medical service?

* General Counsel, Hoosier State Press Association.

Is it a cure-all for defects in national health conditions?

Does it establish a socialistic system through political domination and control of medical, dental, nursing and hospital care?

Does it affect the sovereignty of the individual states?

II

WHAT DOES THE BILL PROVIDE?

Since S. B. 1679 and H. R. 4312 and H. R. 4313 are identical in content, references will be to the former for the sake of brevity. The proposal is authored by eight United States Senators, three of whom have sponsored similar measures in the past. The bill as introduced covers 163 pages with seven titles pertaining to the government-administered and taxpayer-financed program of compulsory health insurance.

Some idea of the far-reaching character of the proposal is obtained by the headings and sub-headings of the various titles that comprise the bill. The seven titles and their contents and provisions are:

Title I—for education in the medical, dental, dental hygiene, public health, nursing, sanitary engineering, hospital administration and related professions. This division provides for payments to schools for costs of instructions, money grants for construction of schools and for equipment, appropriations to states for scholarships. The provisions of this title would be administered by a National Council on Education for Health Professions with matching funds between the states and the Federal government as a factor.

Title II—Provides for medical research, the establishment of institutes and national advisory councils.

Title III—This part of the proposal concerns the expansion of hospital facilities, construction of new hospitals and allotments of funds to states to carry out the purposes.

Title IV—Provides for special health and medical aid in the rural areas particularly toward setting up financial arrangements to induce physicians, dentists, nurses and health workers to locate in sections where there is a shortage of these practitioners. Money grants are also provided in this title for assistance to farmers' experimental health cooperatives.

Title V—This is the part of the bill which provides for money grants to states for carrying on state and local health work. An interesting sidelight is discovered in Sec. 316 (a) of this title, which establishes allotments for "the prevention, treatment and control of various diseases," and among them is listed "the prevention, treatment and control" of other chronic diseases and disorders associated with aging. Herein is created a

new theory that the chronic diseases and disorders associated with old age can be prevented.

Title VI—Provides for research in child life and money allotments to the states for maternal and child health and crippled children's services. Many of the catch-alls in this title are already being handled at the state level but they would be enlarged and subjected to stricter regulations under Federal tutelage.

Title VII—The "meat" of the entire bill has been saved for the final title of the proposal, this providing for the prepaid personal health insurance benefits or what is more commonly known as "compulsory health insurance." Under this title is listed benefits and eligibility; participation of physicians, dentists, nurses, hospitals and others; local and state administration and the establishment of machinery for administration under the guidance of the National Health Insurance Board and local Advisory Councils, the handling of complaints, hearings, judicial review, et cetera.

From a practical standpoint, the provisions of Title I and Title VII furnish the only new features in the system of public health care now in operation. It is around those two parts of the bill that most of the controversy will center, although the cost involved in the government taking over the already established functions of health care is a factor to consider seriously.

III

WHAT WILL IT COST?

Not even the most enthusiastic supporters of the proposal for government control of a national health program, as embodied in S. B. 1679, have more than a vague idea of what the operation will cost once it gets into full swing.

Various estimates of the eventual cost have been given and they range from a low of three and a half billion dollars up to eighteen billion dollars a year. The most optimistic prediction of cost was given by President Truman, in his message recommending establishment of the health program, when he asserted: "Many people are concerned about the cost of a national health program. The truth is that it will save a great deal more than it costs. We are already paying about 4 percent of our national income for health care. More and better care can be obtained for this same amount of money under the program I am recommending. Furthermore, we can and should invest additional amounts in an adequate health program—for the additional investment will more than pay for itself."

The statement is a sample of the loose talk being scattered concerning the cost of operating the proposed health program. Under the provisions of the pending bill, the program will be financed by a tax of 3 percent on the wages of every worker and a tax of 3 percent on the salary or income of

every self employed person up to \$4,800 a year. That means a 3 percent tax on the national payroll plus a 3 percent tax on the first \$4,800 of income received by persons who work for themselves. But adding the national payroll and the first \$4,800 of all persons who work for themselves will not equal national income. So, the conclusion must be reached that under the proposed program, far more extensive health and medical services will be furnished than are available now and at much less cost than is presently being spent for those services. Opponents of the program, who attack it from an economic standpoint, have good reason to question this method of figuring.

In considering the probable cost of the program it might be well to review the financing provisions of two Wagner-Murray-Dingell bills introduced in 1943 and 1945. Both of these measures were for expansion of the Social Security System. The 1943 bill would have established a payroll tax of 12 percent, payable equally by employees and employers. Two years later the same authors introduced a similar proposal for expansion of social security but providing more benefits than the 1943 bill and including an abbreviated system of national health insurance. The 1945 bill called for a payroll tax of 8 percent, payable equally by employees and employers, and 3 percent of which would be allocated to financing the health program. At that time Senator Wagner explained that the reduction in rate from 12 percent to 8 percent does not mean that any of the proposed benefits have been reduced. "On the contrary" he said, "the benefits have been increased." It will be noted that 3 percent of the total 8 percent payroll tax in the 1945 bill was to finance the health insurance project, which, under that measure, did not include all the provisions that are found in S. B. 1679. And yet, regardless of rising costs since 1945, the payroll tax to finance the 1949 proposal is still only 3 percent.

This is a situation which is causing suspicion among those who, while appreciating the value of good health, still feel the wisdom of first determining whether the economy of the nation can support the cost. They point to the fact that at the end of the first year of the health insurance scheme in England expenditures were several billion more than was anticipated and are inclined to go along with the predictions of economists that compulsory health insurance in the United States might easily reach eighteen billion dollars rather than the five or six billion dollars administration leaders have estimated.

Perhaps the man on the street is not so much concerned whether the cost of financing the program is six billion or eighteen billion dollars. Why bother, so long as the insurance rate is only 3 percent? But, the man on the street will be concerned if the cost is two or three times what was expected and Congress is forced to consider whether to increase the payroll tax or increase general taxes to meet the deficit. In either case, the wage earner

will be the hardest hit, either through higher deductions from payroll to meet the compulsory health tax or through increased withholding of tax from payroll to meet the higher general tax bill.

IV

DOES IT INSURE ADEQUATE MEDICAL CARE?

Having disposed of the cost element as one to which there is no answer, it is proper to turn to the next question in considering the operations of a National Health Insurance program as provided by S. B. 1679. Proponents of the legislation will argue, and properly, that betterment of national health cannot be measured in terms of dollars, and that the cost of the program is a small factor when, as President Truman stated: "The investment will more than pay for itself."

But these claims only serve to bring these queries: Will there be a betterment of national health? Will the investment in a payroll tax more than pay for itself in adequate medical care? Will the national health insurance program assure as good medical service as is now being provided? Although Title VII of S. B. 1679 does not give a direct answer to these questions it is just as fair to assume the probable results from an analysis of that section as it is for the proponents of the program to reach the assumptions they have.

Proponents of the program have repeatedly given assurance that the people may choose their own doctors, dentists, nurses and hospitals when the need for service arises. That is emphasized in Sec. 703 of Title VII but it involves a "sleeper" that might go unnoticed. This section reads: "Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: PROVIDED, That the practitioner, medical group, hospital or other person has agreed under part C to furnish the class of services required and consents to furnish such services to the individual." So, there is a catch after all to the freedom of choosing a physician, dentist, nurse or hospital. The catch is found in Part C referred to in the section.

Part C of Title VII covers ten sections and is devoted to the statutory method under which physicians, dentists, nurses, hospitals and others would participate in the program. It specifies who could participate, the type of agreements they would negotiate, how they would be paid, provisions for semi-judicial hearings upon substantial breach of the agreement, all leading to the indisputable conclusion that practitioners who enter into the agreements would be necessarily under government control and domination.

An example of the manner in which governmental political agencies would control the professionals who sign the agreements is found in Sec. 716 (b) of the bill which provides that profes-

sionals who enter into the agreements "shall be responsible, both to the *State agency* and to individuals eligible for personal health services as benefits, for carrying out such agreement made by him or on his behalf." The following Section 717 (d) gives the *State agency* the right to investigate whether a professional under contract is no longer qualified to furnish services, "or has committed a substantial breach of the agreement." In other words, it would rest with a political agency to determine what constitutes a substantial breach of the agreement.

Special provision is made under Sec. 711 of this Title VII for the payment of compensation for specialist services, but only after the Health Insurance Board, (a political agency), has consulted with an Advisory Council and established standards "as to the special skills and experience required to qualify an individual to render such class of specialist services as benefits." This brings up the question of whether all specialists found to be qualified will receive the same compensation for the same services, even though some may be better qualified than others. Under Sec. 718 of the Title is the method of payment for medical or dental services, other than specialist services. Here again, every physician or dentist subscribing to the agreement would be regimented salary-wise to a fee schedule or a per capita basis, or a salary basis, or a combination of these which would be settled on a group arrangement.

Consideration of Title VII should not pass without attention to the provisions of Sec. 719 (c) which appear to foretell a conflict with the claim that individuals will be free to select the professionals of their choice or to change the selection at will. This subsection reads: "Maximum limits upon the number of eligible individuals with respect to whom any person may undertake to render services in any local health-service area may be fixed by the local administrative committee or local administrative officer of that health service area only on the basis of a recommendation of the professional committee in the area that such limitation is necessary to maintain high standards in the quality of medical, dental, or other services furnished as benefits." In other words, if the professional committee determines that a physician or dentist has the maximum number of patients who can be treated satisfactorily, individuals who would prefer their services are stopped from selecting them, so there could be many instances in which there is no freedom of choice.

At least two freedoms have been saved for the professionals who enter into the agreements provided for in Title VII. They can practice their profession in the locality of their own choosing and to a certain extent they can accept or reject patients. But in the latter privilege is a note of inconsistency since the state agency, vested with power to investigate complaints, might reasonably construe the rejection of a patient as a substantial breach

of the agreement entered into by the doctors, dentists, nurses and hospitals.

There is even justifiable reason for doubting the effectiveness of the Bill in the matter of locating physicians, dentists and nurses in the shortage areas. While Title VII permits a professional to choose the locality in which to practice, Title IV, Sec. 402 sets up a special plan that would attract professionals to relieve shortages in rural and other areas. This plan provides for "Grants in the form of guaranties of minimum gross or net incomes or of payments to meet operating expenses or any part thereof, to qualified professional, technical, and administrative health personnel to encourage their location or continuation in shortage areas; and grants for the cost of transportation of such personnel, their families, household goods, or the costs of similar or related items necessary for such location." It is inconceivable to assume that no strings will be tied to the grants or that professionals taking advantage of these gratuities will be permitted to move around at will from one locality to another, even though they are assured that freedom.

So far, the analysis of Title VII has been confined to its effect upon the professional groups because that is the coverage of Title VII and an understanding of that effect is necessary in order to determine reasonably what the people may expect in return for the investment of their payroll dollars. Having established the facts of how the professional groups will operate, we now turn to the question of whether this vast operation will provide adequate medical, dental and health care or the type of care to which the American people have become accustomed.

Starting with the promise that every individual will be eligible for the services, since every individual will be contributing to the insurance program through payroll deductions, the first hurdle is reached in the requirement that the professionals and hospitals must enter into agreement. Unless every physician, every dentist, every nurse and every hospital signs up, the plan cannot be wholly successful. Is it logical to assume that all of them will sign on the dotted line? Many physicians and dentists limit the number of patients they will treat in a day on the theory that the practice of medicine is not a streamline operation. Will they be willing to enter into an agreement that requires them to treat a maximum number of patients per day, some of those patients needing more time and attention than it is possible to give? Suppose all the professionals do sign up and the maximum load of patients is 35 or 40 per day compared to the existing load of 15 or 20 per day, what chance will there be for the really ailing individuals to obtain personalized service they need in return for the payroll dollars they have invested? The history of these plans has been that they have encouraged people least in need of service to seek attention.

Nor is an answer to the problem found in the statement that a majority of the professionals in England signed up under the health insurance program there and that this is a criteria of what may be expected in the United States. In the first place, the people of England, including the professionals, have entirely different characteristics than the people of the United States. The motoring speed limit in England is 35 miles an hour and people there observe it because the government has decided that is the safe speed to travel. The government of England decided that a health insurance program should be established and the people of England, including the professionals, fell in line because it is a characteristic of the English people to subscribe to what the government decrees. Furthermore, the English people have gone through the war years and since under rigid regimentation, so it is no new experience for the people to wait and wait and wait. But, the professionals of the United States have never been regimented and it is doubtful whether within the present generation they could become accustomed to practicing under a maze of government rules and regulations. By the same token, it is doubtful whether the people of the United States, having paid each week into a fund for medical, dental, nursing and hospital services, would be sufficiently patient to wait for hours on hours in a crowded physician's office, or for weeks to obtain a tonsillectomy, or for months before hospital facilities are available to undergo major surgery. This is what has happened in England, but the people of the United States are not gifted with that ultra degree of patience.

Why is it so important that every physician, every dentist, every nurse and every hospital sign up to participate in the health insurance program? Here is a question which proponents of the plan have soft-pedaled. But it is a highly important question to the man on the street, if not the most important question. Considerable emphasis is given by proponents of the proposal to the theory that all individuals may select the doctors and dentists of their choice and change the selection at will, although, as we have shown by the bill itself, this has its limitations. But that freedom of choice rests on the proposition that all doctors, dentists, nurses and hospitals will sign the agreement to provide the services for which all individuals will make advance payment. If they do not sign up, then health and medical care will be more expensive than it is now for those individuals who prefer a doctor, dentist, nurse or hospital not signed up. They will not only have the expense of deduction from the payroll envelope to finance the compulsory health program but they will also have the additional expense of fees charged by the doctors they prefer to minister to them and their families. Such a situation cannot be laughed off as being improbable. It is quite possible that many of the best doctors in a community, or that all the doctors in a community, might refuse to sign the agreement for reasons they feel are justifiable.

Certainly the people who will ultimately be most affected by the operation of a national health insurance plan, deserve to be told the complete story and to be given all the facts. It is nothing short of cruel to present only half-truths, as was done in a recent issue of *The Guild Reporter*, publication of the American Newspaper Guild, which, after explaining that the average worker making \$100 a week would pay \$72 a year for all the services, and then stated:

"In return, you and your family would be assured of all the hospital and medical care you needed, plus expensive medicines and appliances. Limited dental care would be provided, if available funds permitted, along with necessary nursing care. You could go to your regular family physician, or any other doctor participating in the plan. Probably nearly all the doctors would participate. You could change physicians if you wished. * * * Doctors could go into the plan or not. They could accept or reject patients as they do today. * * * The same freedoms would prevail for hospitals."

If it were all as simple as that there would be no controversy. Workers and their families are assured of hospital and medical care only to the extent of available facilities. Workers and their families could go to their regular family physicians only if their regular family physicians have signed the agreement and then only if their regular family physicians have not reached the maximum number of patients they can handle satisfactorily. And if doctors could accept or reject patients as they do today, what advantage is there to the freedom granted workers and their families in choosing doctors who might reject them?

The average American has reason to be concerned over the effect which the provisions of Title VII will have on him and his family. A contribution of \$72 a year in payroll tax from a wage of \$5,200 a year for all the services promised may seem trivial and appeal to the shopper's instinct of getting something for nothing. But a close study of this plan may disclose that bargain hunting is rarely productive of top value merchandise. When health and medical care is involved top value service is essential.

V

IS IT A CURE-ALL FOR DEFECTS IN NATIONAL HEALTH CONDITIONS?

While S. B. 1679 is given the title "National Health Insurance and Public Health Act," a thorough digest of the measure and its provisions leads to the deduction that the title is a misnomer. The proposal, so far as it affects public health conditions, is largely an expansion of existing operations. Therefore it must be obvious that the chief feature of the measure is that contained in the new provision concerning the practice of medicine, dentistry, nursing and the operations of hospitals.

It appears then that the better title for the bill would be "National Public Medical, Dental, Nursing and Hospital Act."

Throughout the new features of the proposal, emphasis is directed at the alleged importance of medicine, dentistry, nursing and hospitalization as the principal factors in maintaining health standards. As a matter of fact, these agencies, with the possible exception of dentistry, are a haven of last resort to which people turn when good health has deteriorated. It is true that some folks have a complex that causes them to enjoy seeing the doctor. But a vast majority of the people steer clear of doctors until they are in need of medical service and often that need is due to their own neglect of their health. Nothing the medical profession can do will correct that situation. People contract diseases or fall into poor health because of other factors than lack of medical attention.

What are some of those factors? Food, clothing, housing, rest from work and recreation, sanitation, are probably the most essential elements to be considered in maintaining high health standards. None of these has anything to do with medicine per se, and with the exception of the public sanitation factor there is nothing that government can do on a compulsory basis that will serve as a preventative of poor health conditions when there is a breakdown of the other elements.

It is a known fact that lack of food or a diet of improper food causes malnutrition, which can and does bring on poor health. If the purpose of a national health insurance law is to achieve better health, it would seem logical that it should go to the source rather than to the cure, as S. B. 1679 seeks to do. This would involve placing every distributor of food under government control to dispense the right kind and the proper amount of food to every family which pays its food bill in the form of a payroll tax. The same principle might be applied to the clothing angle, for insufficient and improper clothing is often the cause of colds and illnesses that must be accepted as a breakdown in health. Poor housing conditions and the failure of individuals to obtain the proper amount of rest from work or from strenuous recreation are certainly contributory to poor health. And while municipal government generally has reached a high standard in maintaining public sanitation there is no power on earth that can prevent the poor health and disease that is due to lack of private cleanliness.

Assuming that a problem exists, the question is whether S. B. 1679 presents the answer. It appears to be more in the nature of "locking the barn door after the horse is stolen" as far as any effect it will have in creating better health conditions. If it were possible to legislate the distribution and use of food, clothing, housing and to require normal rest and personal sanitation by individuals, the problem of medical care would be fairly insignificant. The conclusion that must necessarily be

reached is that under S. B. 1679 the causes of poor health are not so important as long as a cure or treatment is provided when illness arises that could often have been prevented in the first place.

VI

IS IT SOCIALISTIC?

Throughout this analysis of S. B. 1679 and H. R. 4312 and 4313 use of the word "socialistic" has been avoided, purposely. The framers of the proposal have not used it, purposely. Administration leaders have referred to the term negatively, in denying that the national health insurance program is the establishment of socialized medicine, knowing full well that the average American citizen wants no truck with anything socialistic. For the same reason, the opponents of the proposal have contended that the program sets up a system of socialized medicine and as proof point to its counterpart operating in the socialist, fascist and communist nations of Europe.

All this means very little to the average American citizen, who visualizes the millenium in medical attention from promises of administration leaders and in the next instant faces the threat of inadequate medical care in the warnings of those who oppose the proposition. What the average American citizen wants to know is which side is spoofing him.

Socialism has been defined as the doctrine under which the government owns, operates and controls, and which is the opposite of individualism. Provisions in the bill that permit the free selection of physicians, dentists, nurses, the freedom of these individuals to locate where they please, to enter or not enter into the program, the freedom of medical schools from any governmental supervision over training courses, all point to the overall operation being devoid of any tinge of socialism.

But there is more to socialism than ownership and operation. Obviously, the government would not own or even operate the professions of medicine, dentistry or nursing if the National Health Insurance program is put into effect. However, the definition of socialism includes the factor of control as well as ownership and operation, so it becomes necessary to turn to that in determining whether the program has or might have socialistic aspects. The issue is akin to that which always arises in determining whether an individual is an employee or an independent contractor.

If the power to control is present, there cannot be complete independence of operation. Therefore, the copious assurances of freedom and independence given in S. B. 1679 and H. R. 4312 and 4313 are only empty words if conduct of those affected by the program is subject to even a minimum of control, directly or indirectly administered. But it must be admitted by even the most militant supporters that operation of the proposal involves

both direct and indirect control. Throughout the bill and under every title are the regulations that must be observed. To regulate is to control. The students who accept gratuities from the government in the form of scholarships are regulated, the people who are forced to contribute to the financing of the program are regulated, the doctors, dentists, nurses and hospitals are regulated, all through agreements and processes over which they have no control but which are established as a means of controlling them.

Under this kind of proposition such control by government is not unwarranted. The Congress decrees by law that every person must set aside a stipulated amount each payday for certain professional services. That carries with it the necessity for control over the distribution of the funds and control over the practices and habits of those who accept benefits. There is no other way out.

It would be ridiculous for the people, the physicians, dentists, nurses, hospitals, to expect this health program to function without government control. And when government takes over control, particularly in the distribution and allocation of funds on an "all for one and one for all" basis, the principle of socialism is present. Inasmuch as the proposed national health program could not possibly be carried on without government controls that might be intensified at the will of administrative officials, it is not unfair to hold that the program would be socialistic in character as well as in practice.

VII

DOES IT AFFECT STATE SOVEREIGNTY?

Perhaps this is the least important of all the angles to consider when delving into the provisions of S. B. 1679 and H. R. 4312 and 4313. But there are many people who still want to feel that the state in which they reside has some rights reserved to it. Those who drafted the National Health Insurance measure evidently recognized that fact and sought to appease it but the effort falls short of anything but to emphasize the low level to which state governments have dropped.

After devoting five sections to the method of local administration by local committees or officers, local area committees, local professional committees, the measure reaches that part which each state would take in the operation of the national health program. Part E, of Title VII at Sec. 741 announces that "It is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States * * *." Then follows Sec. 742: "Any State *desiring* to assume responsibility for the administration in the State of the personal health-service benefits provided under this title to all individuals in the State who are eligible for such benefits may do so for the period beginning July 1, 1951, or for the period beginning July 1 of any succeeding year,

if it has undertaken through its legislature, to administer such benefits in accordance with the provisions of this title and with the provisions of regulations and standards prescribed thereunder, and at least twelve months in advance, has submitted and had approved a State plan of operations." Then follows seven provisions which must be incorporated in the state plan and from which there must be no deviation.

Attention is directed to what must be done by any state *desiring* to participate in the program. What happens if a state does not desire to participate? What happens if the legislature of a state decides the program is unworkable, or too costly, or too socialistic, or gives the Federal government too much authority over the people within the state and over the state itself?

Frankly, there is nothing any state can do about it. If the legislatures of 48 states turned thumbs down on the program, it would still be put into operation, for Sec. 742 (d) reads: "If a State has not prior to July 1, 1950, submitted and had approved a plan of operations, the Board shall notify the Governor of the State that the Board will be required to administer this title in the State, commencing July 1, 1950." The Governor is given 60 days, after receiving the notice, in which to set up a state plan and if this is not done at the end of the 60 days, the Board moves into the state, sets up a program "and shall continue such administration until one year after the submission and approval of a plan of operations."

The Board, to which reference is made herein, is a group of five persons, "three of whom shall be appointed by the President by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security." The latter two are usually political appointees. Therefore, it must be assumed that operation and control of the program from a national angle and over the states would have at least a shade of partisan political complexion.

Every state would be required to adopt and conform to a plan in which it has no part in the making. The only degree of sovereignty a state would retain would be in the administration of the law and then under the orders and control of a national board that would be supreme authority in the final analysis.

VIII

SUMMARY

Proposals as revolutionary and costly as those contained in the National Health Insurance measure are certain to produce doubts and arguments. These cannot be settled by bitterness and name-calling. Nor can they be settled by permitting the people to remain in ignorance or in a state of confusion. One vehement opponent of the National

Health Insurance program recently admitted he had never read S. B. 1679. On the other hand a labor organization assures its members they will get all the medical care they need and more too, and pay very little for it, which indicates that a proponent of the proposal also has neglected to study it thoroughly.

As stated at the outset, the purpose of this analysis has been to present the facts and the conclusions to be reached from a digest of those facts, in order that the people may be fully informed and thereby not support or oppose the proposition blindly. It cannot be denied that, on its face, the proposal might appear to solve a problem. Not a problem for betterment of national health because the measure will just not do that, since human beings are as they are. Nor does digging into the facts indicate that the proposal will solve what S. B. 1679 describes as "our archaic system of paying for medical care—based on public and private charity for the poor, on unpredictable and often unbearable costs to the otherwise self-supporting; and on disproportionate charges for the well-to-do." There would still be charity in the system of paying for medical care under the proposal, since the family which receives more medical care than has been paid for through payroll deductions would, in fact, be receiving charity. The only change in the system would be that more people would be contributing to the upkeep of charity.

Admittedly, there is a problem and it is sensed most strongly by the great middle class. Perhaps this explains why organized labor has voiced its support to the proposal for a national health insurance program, and is the only formidable group to take that position. It can hardly be said that

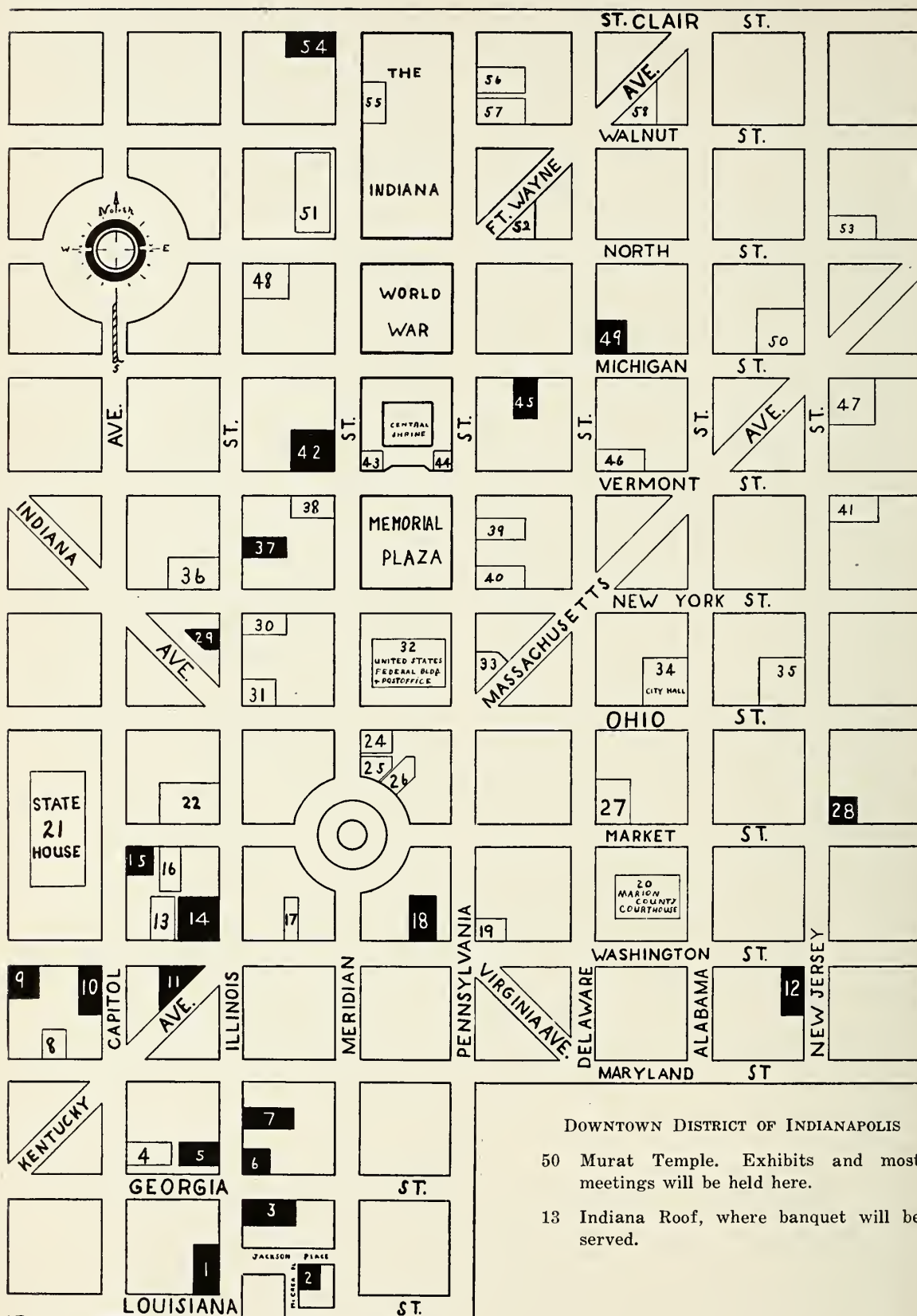
labor leaders, if they analyze the proposal, can support it because it is a "labor gain." As a matter of fact, the health and medical program means less take-home pay in return for impersonalized medical care. Nor can labor leaders count as a gain the establishment of a system which places every individual under the control of government. Samuel Gompers, President of the American Federation of Labor, ably handled that in an address on December 5, 1916, when he said:

"There has never yet come down from any government any substantial improvement in the condition of the masses of the people, unless it found its own initiative in the mind, the heart and the courage of the people. Take from the people of our country the source of initiative and the opportunity to aspire and to struggle in order that that aspiration may become a reality, and, though you couch your action in any sympathetic terms, it will fail of its purpose and be the undoing of the vital forces that go to make up a virile people. Look over all the world where you will and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people. * * * When compulsory health insurance and compulsory unemployment insurance are proposed, the question arises at once, 'What are the conditions and regulations to be imposed by the government to regulate the conduct of the supposed beneficiaries?'"

Nothing more effective can be said in terminating the analysis of S. B. 1679, which undoubtedly is neither a panacea nor a solution to a problem that should be met by people who have initiative and courage, rather than by those who prefer regimentation and regulations.

CENTENNIAL CONVENTION GOLF TOURNAMENT

All golf players are invited to participate in the Centennial convention golf tournament at Highland Golf and Country Club, Indianapolis, Monday, September 26. Plenty of prizes! Players will tee off from 12 noon to 2 p. m. If you plan to compete, please notify Dr. B. Kemper Westfall, 2901 East 38th Street, Indianapolis 18, chairman of the Golf Committee.



DOWNTOWN DISTRICT OF INDIANAPOLIS

50 Murat Temple. Exhibits and most meetings will be held here.

13 Indiana Roof, where banquet will be served.

NEED A HOTEL RESERVATION FOR THE STATE MEETING?

(Indianapolis, September 26-29, 1949)

Start Calling Doctor Gillespie!

Don't stay at home because you haven't a hotel room for the I.S.M.A. convention—**Dr. Jacob E. Gillespie and his Housing Committee will get you a room.**

Write to Doctor Gillespie . . . **not to a hotel** . . . if you need a room. Use form below.

FOUR BIG DAYS AND NIGHTS

Monday, September 26—Stag party for men. Party for women.

Tuesday, September 27—Concert by Baltimore & Ohio Railroad Glee Club.

Wednesday, September 28—**National** speaker on semi-scientific subject.

Thursday, September 29—Annual dinner, followed by dancing to name band.

—————

**Scientific Lectures and Television
Every Day**

Hotels	Rates
(Numbers Indicate Locations. See Map on Opposite Page)	
54 Antlers	\$3.75- \$8.50
2 Barnes	\$2.00- \$6.00
49 Barton	\$2.25- \$7.00
14 Claypool	\$4.00-\$10.00
* Graylynn	\$4.00- \$6.00
15 Harrison	\$3.25- \$8.75
11 Lincoln	\$3.50-\$10.00
37 Linden	\$2.00- \$6.00
* Marott	\$4.50-\$10.00
* Pennsylvania	\$2.75- \$5.00
* Riley	\$2.25- \$6.00
3 Severin	\$3.50-\$10.00
* Sheffield	\$3.50- \$7.00
1 Spencer	\$2.50- \$6.00
42 Spink-Arms	\$3.00-\$12.00
17 Stratford	\$2.00- \$6.00
7 Warren	\$3.50- \$8.50
18 Washington	\$3.25- \$8.50
9 Williams	\$2.25- \$6.00
29 York	\$2.00- \$5.00

* Not shown on map.

HOTEL RESERVATION BLANK

Clip and Mail this coupon to Dr. Jacob E. Gillespie, 1201 Roosevelt Bldg., Indianapolis 4, Ind.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, September 26, 27, 28 and 29, or for such other period as may be indicated herein.

☐ Single Room with bath

☐ Double Room with bath

Price:.....

☐ Twin Bed Room with bath

☐ Suite

Arrival dateA. M.P. M.

Departure dateA. M.P. M.

Hotel Choices

Name

First

Address

Second

.....

Third

.....

Fourth

REPORT ON ROUND-THE-CLOCK MEDICAL SERVICES PROVIDED BY COUNTY MEDICAL SOCIETIES

HOW well is the medical profession providing emergency medical services for its communities?

The Committee on Publicity decided to get the answer to this question. Questionnaires were mailed to secretaries of all Indiana medical societies.

The returns revealed that twenty-four hours a day, every day of the week, emergency medical services are available in all but a few communities.

The results of the survey by county societies, as of July 11, follows:

COUNTY

ADAMS

Berne—Physicians' Exchange and arrangement among doctors to have at least one on duty over week-ends and holidays. All make night calls and take different afternoons off.

Decatur—Staggering afternoons off. Arrangement among doctors to have at least one on duty on week ends and holidays. Patients can call hospital and call will be transferred to doctor on call.

ALLEN

Do not have this service.

BARTHOLOMEW-BROWN

Medical and surgical roster. Some M.D. always on call day and night.

HOONE

Hospital switchboard until 10:00 p.m. and then through police station after 10:00 p.m.

BENTON

No report received.

CARROLL

Do not have this service.

CASS

Through physicians' exchange.

CLARK

Clark County Hospital switchboard is used as an exchange from which a doctor can always be obtained.

CLAY

Each doctor has listed in the telephone directory an alternate number (hospital number). When a doctor is leaving town for a few hours we notify the hospital, and let them know when we return. At all times (Sundays and Thursday afternoons) there are sufficient doctors to take care of emergency cases.

CLINTON

Four doctors take all emergency calls on Thursday afternoon and all others cover Wednesday afternoon. A roster is kept at hospital and a doctor can be located at any hour.

CRAWFORD

Do not have this service.

DAVIESS-MARTIN

A doctor serves a week at a time for emergencies and his name and number is listed at the hospital.

DEARBORN-OHIO

Days off are staggered in each city of Rising Sun, Aurora and Lawrenceburg.

DECATUR

One doctor is on call day and night at the hospital for all week, for any calls not answered by the regular physician.

DEKALB

Each city in the county always has someone available by mutual agreement among the doctors. Furthermore, each doctor nearly always covers himself if he will not be available.

DELAWARE-BLACKFORD

No report received.

DUBOIS

A doctor is on 24 hour call at The Stork Hospital in Huntingburg. This service is operated by Dr. H. K. Stork.

ELKHART

Goshen has round-the-clock medical service. Elkhart is organizing such a service. A group of the younger doctors will take turns being on call at the hospital.

FAYETTE-FRANKLIN

One doctor assigned to be on duty on Thursday, Sunday and holidays.

FLOYD

24 hour physicians' exchange. Certain physicians on call for week ends.

FOUNTAIN-WARREN

Do not have this service.

FULTON

13 members of county society. One member on emergency call at county hospital at all times, another acting as alternate. Service for each member one month a year. If patient cannot contact family physician, physician on emergency call takes charge until family physician can be contacted.

GIBSON

Do have service.

GRANT

No report received.

GREENE

If anyone is unable to find a doctor in his community, the hospital will find a doctor for him.

HAMILTON

Physicians in the various towns and cities of this county have arranged to take care of their respective communities by seeing that a physician is on duty at all times, day off and holidays.

HANCOCK

Have the hours and days arranged so we are not without service for the public at any time. Works quite well. Each physician has his hours and days so there is no time when a physician may not be secured.

HARRISON

A doctor is always available.

HENDRICKS

Each M.D. is subject to individual call.

HENRY

Do not have this service.

HOWARD

We are working on a 24 hour service, using the hospital switchboard operator as a telephone exchange.

HUNTINGTON

Physicians stagger days off and hospital furnishes service for patients unable to locate a physician.

JACKSON

Names of two physicians are on file at hospital, available for such services, day, night and holidays.

JASPER-NEWTON

One man is on emergency call at the hospital at all times.

JAY

Rotating turns being on call on week ends and holidays.

JEFFERSON

No report received.

JENNINGS

Two men remain in their offices Wednesday afternoon and evening and then take Thursday afternoon off. The balance take Wednesday off. We are a group of small town G.P.'s and take care of the public at all hours.

JOHNSON

Doctors alternate on call list at hospital for Wednesday, Sunday and holidays. Night calls handled by individual doctors. Emergency lists for surgery, obstetrics, medical services, on file at hospital.

KNOX

Physicians' exchange.

KOSCIUSKO

For all emergencies the hospitals maintain a roster. There is no central service otherwise.

LA GRANGE

Each doctor on 24 hour call. Not an hour in the week that some doctor cannot be found.

LAKE

Physicians' exchange in Gary, Hammond and East Chicago.

LA PORTE

Doctor on call at hospital at all times of day and night. Have a city physicians' bureau.

LAWRENCE

2 doctors on call each month and may be reached through Dunn Hospital, Bedford. 14 doctors participate in program.

MADISON

One doctor on 24 hour call each day at hospital. A number of doctors keep office hours on other doctors' day off. Physicians' and Surgeons' exchange on 24 hour call.

MARION

All hospitals, police and fire departments and two answering services have list of approximately 75 doctors who will accept emergency calls at any time.

MARSHALL

When a doctor leaves town he makes arrangements with another doctor to take his calls.

MIAMI

Rotating service by hospital staff.

MONTGOMERY

Doctors take their turn at emergency calls on Wednesday p. m. in Crawfordsville. Doctors in county do not enter into this program. Doctors can be located through the hospital switchboard at practically any time.

MORGAN

Martinsville has doctors assigned to emergency calls at hospital for week ends and days off. No round-the-clock service for other communities in Morgan County.

NOBLE

Someone always available through telephone exchange.

ORANGE

Doctors' exchange located at Paoli and serves the county.

OWEN-MONROE

Plans being formulated to establish a service where at least one-third of the active physicians will be available for office and home care of patients during the days off. Emergency service maintained at all times at the Bloomington Hospital.

PARKE-VERMILLION

No report received.

PERRY

A physician available at all times.

PIKE

Do not have a specific system since county is short on doctors. A doctor is always available.

PORTER

One doctor and alternate on call for a week at the county hospital. A doctor may be reached at any time by calling the hospital.

POSEY

Do not have service.

PULASKI

One doctor available on Sunday, holidays and afternoons off.

PUTNAM

Two doctors on call at all times. Rotation on a weekly schedule. Physicians' exchange obtains one of the doctors on call if family physician is not available.

RANDOLPH

Formulating such a service.

RIPLEY

Doctors' day off staggered. All doctors on 24 hour call unless it is his day off.

RUSH

An unwritten agreement among the doctors that at least two are in reach of a phone at all times. Works very well.

ST. JOSEPH

Three phone exchanges have a list of physicians available for emergency calls. Classified section of telephone directory carries the numbers of exchanges. Service has been in use for several years.

SCOTT

Four doctors in county. Each doctor takes a different day off and takes care of the necessary night calls.

SHELBY

Poster posted at hospital. Office staff of hospital acts as clearing house for emergency calls.

SPENCER

No definite plan. Each doctor responsible for his own patients.

STARKE

No report received.

STEUBEN

Physicians available on call 24 hours through two private hospitals in county.

SULLIVAN

Local hospital will locate doctor.

SWITZERLAND

Doctors always available.

TIPPECANOE

Names of two physicians each week on file at hospitals for emergency calls.

TIPTON

Doctors in county take different days off.

VANDERBURGH

Does have round-the-clock service.

VIGO

List of doctors at doctors' exchange. Ad in telephone book. Had newspaper publicity. Operates very satisfactorily.

WABASH

Hospital keeps call for M.D's. Works fairly well.

WARRICK

Do not have service.

WASHINGTON

Do not have service.

WAYNE-UNION

Switchboard operator at Reid Hospital acts as our exchange, and is so listed in the telephone directory, and gets a doctor to make any call.

WELLS

Doctors at Ossian arrange to give round-the-clock service. Bluffton doctors provide this service. Service adequate at present time.

WHITE

Service adequate.

WHITLEY

Each physician is allegedly responsible for his own round-the-clock service.

INSTRUCTIONAL COURSES

THIS issue of THE JOURNAL contains the curriculum of the Instructional Courses to be presented on the opening day of the Centennial Session of the Indiana State Medical Association. It appears on page 804.

The committee in charge has profited by the experience gained in its work since this feature of the Annual Session was first offered in 1943. Thirty classes are presented by members of the Indianapolis Medical Society. Each class is conducted by an instructor who has distinguished himself in the field of medicine which he will discuss. Locally it is considered an honor to be chosen as an instructor. All remain anonymous until the class convenes. It is the instruction, not the instructor, which is stressed.

The committee has endeavored to so arrange the curriculum as to permit the coordination of a series of five classes with minimum conflicts. The usual difficulty is for the student to decide which classes to omit in order to attend the ones he considers of greatest value to him in his practice.

The committee has provided that the topics discussed be so presented as to offer the member in general practice the latest points of view and the most accepted practical techniques in a manner permitting him to obtain usable professional tools. Theoretical discussions are minimized. Practical values are stressed. It is a student's course, not an instructor's forum.

The committee wishes to emphasize that the Centennial Session begins on *Monday*, September 26, 1949, at Murat Temple in Indianapolis. This is Registration and Instructional Course Day. The first classes start at 11 a.m. You will want to attend this session of the Association and you will want to enjoy the Instructional Courses. Begin to plan now to reach Indianapolis well before 11 a.m. on Monday, September 26, 1949.

Each Instructional Course class is limited to an attendance of 30 students, in the interest of proper classroom technique. To insure your entrance at the classes you wish to attend turn to page 804 of this issue and place your order today. Most classes are filled prior to the opening of the session, though there have been some vacancies available at Registration. The policy is first come, first served. Send your order for classes early, today, now.

AMENDMENTS TO CONSTITUTION TO BE VOTED ON AT THE INDIANAPOLIS SESSION, 1949

At the 1948 annual session in Indianapolis, the House of Delegates voted to accept the revised Constitution and By-Laws of the Indiana State Medical Association, which included changes proposed by the 1948 Committee on Amendments to the Constitution and By-Laws and also by the 1948 Reference Committee on Amendments to the Constitution and By-Laws.

To conform with Article XIV of the Constitution which states that "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in *THE JOURNAL* of this Association," the entire Constitution is printed here. Words, phrases, sentences, or paragraphs which are to be replaced or abolished are inclosed in parentheses, while the newly accepted amendments are printed in bold face type.

CONSTITUTION OF THE INDIANA STATE MEDICAL ASSOCIATION

ARTICLE I—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the (entire) medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of (state medicine,) **medical care**, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV—COMPOSITION OF THE ASSOCIATION

(Section 1.—This Association shall consist of Members, Delegates, Guests, and Associate and Honorary Members.)

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members, and Honorary Members.

(Sec. 2.—*Members*.—The members of this Association shall be the members of the component county medical societies. Membership in a county medical society on a basis not including membership in the Indiana State Medical Association is not recognized.)

Sec. 2.—*Active Members*.—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

(Sec. 3.—*Delegates*.—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.)

—Sec. 3, above, is to be omitted. The present Sec. 4, therefore, will become Sec. 3.—

Sec. 3.—*Associate Members*.—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

(Sec. 5.—*Honorary Members*.—Honorary members shall consist of representative teachers and students of science allied to medicine and of physicians and surgeons of distinction not members of the Indiana State Medical Association, who may by vote of the House of Delegates be elected to honorary membership; and any physician of the State of Indiana who has attained the age of seventy-five years and has held membership in the Indiana State Medical Association for twenty years or more may be elected to honorary membership by vote of the House of Delegates, provided his name be proposed for such honorary membership by the county medical society of which such physician is a member.)

Sec. 4.—*Senior Members*.—Senior members shall be physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members*.—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

(Sec. 6.—*Guests*.—Any distinguished physician not a resident of this state who is a member of his own State Association may become a guest during any Annual Session on invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that session.)

Sec. 6.—*Rights and Privileges of Members*.—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive "The Journal" of the State Association, they shall pay the regular subscription fees therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. **The following shall be ex officio members:** the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, (Executive Secretary), Treasurer, and two councilors-at-large as hereinafter provided. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. (Five) **Seven** Councilors shall constitute a quorum.

(ARTICLE VII—SECTIONS AND DISTRICT SOCIETIES)

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. **Councilor districts shall be defined by the House of Delegates.**

(ARTICLE VIII—SESSIONS AND MEETINGS)

(Section 1.—The Association shall hold an Annual Session during which there shall be held daily general meetings and such section meetings as may be provided for, all of which shall be open to all registered members and guests.)

ARTICLE VIII—CONVENTIONS AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

(Sec. 2.—The time and place for holding each Annual Session shall be fixed by the House of Delegates at the preceding Annual Session.)

Sec. 2.—The House of Delegates shall select the place for two years in advance for holding the annual conventions. The time for the conventions shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special (sessions) meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. **Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with section 4 of this article.**

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates (on the morning) as the first order of business of the last day of the Annual (Session) Convention, and no person shall be elected to any such office who is not in attendance on that Annual (Session) Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each councilor district shall elect an alternate councilor whose term of office shall be the same as the councilor, namely three years. The alternate councilor shall be elected in a year during which there is no councilor elected.

The duties of the alternate councilor shall be:

1. To represent the council district in the absence of the regularly elected councilor.

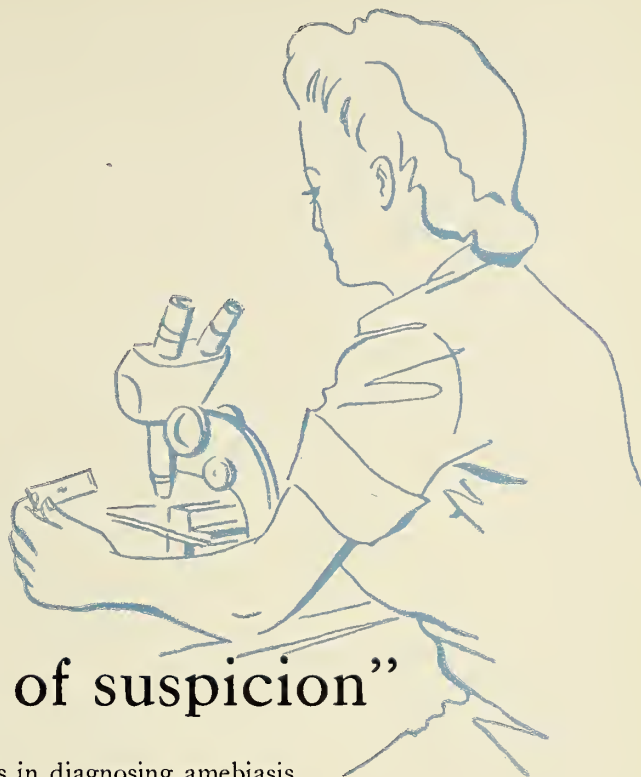
2. To vote only in the absence of the regularly elected councilor either in the House of Delegates or in Council meetings where he represents the regularly elected councilor.

3. The alternate councilor shall not have the power of discussion if the regularly elected councilor is present, but he shall attend all meetings of the Council, unless he has a reasonable excuse for not doing so.

4. The retiring president shall serve as councilor-at-large for a period of two years following the expiration of his term as president.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become president pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing mem-



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1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, New England J. Med. 235:678 (Nov. 7) 1946.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," Glasgow M. J. 27:123 (May) 1946.

bers to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Connellors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

(ARTICLE XI—FUNDS AND EXPENSES)

(Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds also may be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publication, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.)

ARTICLE XI—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual (Session) **Convention**, provided that such amendment shall have been presented in open meeting at the previous Annual (Session) **Convention**, and that it shall have been published twice during the year in *THE JOURNAL* of this Association.

The September issue of *THE JOURNAL* will carry the entire Constitution and By-Laws, as approved by the House of Delegates in October, 1948. Final vote will be taken at the second meeting of the House of Delegates on Thursday, September 29, 1949, at Indianapolis.

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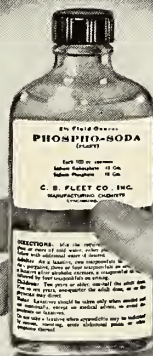
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HOW TO "CONTACT" YOUR CONGRESSMAN

We are being exhorted daily to communicate with Senators and/or Representatives, not only on medical legislation but also as ordinary citizens on a variety of matters. One naturally wonders how he can best gain and hold the attention of a legislator. *The Wisconsin Medical Journal* for June, 1949, offers the following information, apparently obtained from a Senator, himself:

"The eight pointers listed below were named by a United States Senator as the most effective procedures in bringing to the Congressman the opinions of his constituents:

1. **Personal conversation** with Congressman at home.
2. **Telephone conversation.** If a personal conversation is impossible, then speak to him over the telephone.
3. **Hand-written letter.** If a personal conversation or telephone conversation is impractical, then write a letter in longhand. It does not need to be lengthy but should clearly demonstrate the writer's point of view.
4. **Typewritten letter.** A typewritten letter is not as effective as a letter written in longhand because it seems not to indicate the amount of effort given to a letter written in longhand.
5. **A telegram.** A telegram is less effective than any of the preceding because it is usually brief, frequently indefinite, and nothing to indicate certainly that the signer was the sender.
6. **Resolutions.** The effectiveness of resolutions can be increased by follow-up on the part of the senders sent in one of the ways mentioned above.
7. **A representative of a national organization** to which the constituent is a member may call upon the Congressman as a follow-up to the constituent's message with the endorsement of the national organization.
8. **Petitions** are of little value. Effectiveness is directly related to personal relationship established by constituents."

WE'RE "FROM MISSOURI," TOO:

The Journal of the Missouri State Medical Association quotes the following, by J. Phil. Edmundson, M.D., published in *The Jackson County Medical Society Weekly Bulletin*:

"In a recent radio broadcast, Samuel B. Pettingill, 'The Gentleman from Indiana,' comments upon the sad state of Britain's system of Socialized Medicine. Says he: 'Britain's Minister of Health, Mr. Bevan, is amazed at the "bad sight" which his countrymen are developing. The rush for spectacles is so great that it has overtaken

production capacity.' One might well question the vision of the planners of such a system in the first place. Manifestly it was somewhat less than 20/20.

"In a more recent news item, as reported by the Associated Press, Mr. Bevan was accused of unfairness in passing out glasses under the socialized national health law. A Dr. Edward Erdei wrote in the *British Medical Journal* that the Ministry is refusing free spectacles to all persons whose pupils are more than 2.8 inches apart. Said he: 'Wider-set eyes are not accepted by the Ministry as probably not conforming with the specifications of the human race as laid down by one of its committees.'

"Well, we expected quite a distance to occur between the promises and the fulfillment of Britain's health plan, but we did not think it would so soon affect pupillary distance. If, in fact, Mr. Bevan's 'amazement' at his countrymen's visual deficiencies is of the 'wide-eyed' variety, even this estimable gentleman's own spectacles may soon require adjustment, and out of his own pocket! However, as we understand it, the fitting of glasses somewhat involves the matter of frames, and it becomes quite evident the British people were 'framed' long before spectacles entered the picture.

"Not quite comparable, but nevertheless remindful of government bungling, we recall our own late lamented Prohibition Act. Under its beneficent mandates distilled spirits were legally recognized as medicinal agents, and, as such, were prescribed and dispensed by physicians and druggists, respectively. Medicines, being designed and intended for the cure or alleviation of disease, it is a natural assumption medical men would be the logical ones to determine how they should be used. But did the Government regard the matter in this light? Not by a jugful, Brother. Uncle Sam said that one pint of 'likker' had to last a patient ten days, come hell or high water, and neither double pneumonia nor double indemnity could change it a single ounce.

"It may well be argued that Spiritus Frumenti, purely as a therapeutic agent, is readily expendable, but this in no wise affects the principles governing such matters. If the politicians and bureaucrats are to set up a system of standards by which we or the British are to practice medicine, the implications are so far reaching as to stun the imagination. Already British ophthalmologists are having the tools of their trade interfered with. What if this 'standardization' should be carried to its logical conclusion?

"Once the pupillary distance allowed under the law be fixed, why not the length, let us say, of ureteral catheters? There is no good reason, within such logic, why the distance allowable between the kidney and the bladder should not likewise become a matter of law. Or the size and length of Graves' specula, which would affect us personally, to say nothing of the dear ladies who expect us to use both gentleness and judgment in such delicate matters. This may stretch—pardon us—the imagination somewhat, but if it is Socialized Medicine you want, and that is exactly what is proposed by our own Mr. Ewing in his Compulsory Health Insurance Plan, then by all manner of means—"Buy British!"

That was a long "quote,"—but honestly, now, didn't you enjoy it? Perhaps we could use a few more uninhibited people like Dr. J. P. E. If you happen to be one, why not send ye editor a few choice Hoosier comments?

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News Notes

Dr. Charles W. Myers, superintendent of the General Hospital, at Indianapolis, was chosen to receive the annual good government award by the Indianapolis Junior Chamber of Commerce. This honor was bestowed upon Doctor Myers "In recognition of meritorious contribution and initiative in public welfare." Head of the hospital since 1930, Doctor Myers "exemplified selfless service and personal sacrifice . . . to expand and improve the hospital for greater service."

Dr. A. W. Ratcliffe, of Evansville, has announced that he has left his post as pathologist at St. Mary's Hospital there, to devote full time to his laboratory and practice, limited to pathology, at 510 S. E. First Street, Evansville.

Dr. William B. Dublin, formerly pathologist at Indianapolis General Hospital, has gone to Fort Logan, Colorado, where he is associated with the VA Hospital there, in the pathologic division. The hospital is affiliated with the Colorado School of Medicine, and Doctor Dublin will have a teaching assignment.

Dr. R. L. Braunsdorf, a graduate of Michigan University in 1939, has announced the opening of his new office in Rensselaer. Following two years of internship in Detroit, Doctor Braunsdorf had two years of special training in surgery. He entered private practice in 1939 in South Bend.

The Huntingburg Stork Hospital recently announced that Dr. Sam Boswell, of Evanston, Illinois, has joined the hospital staff. Doctor Boswell is a graduate of Northwestern University School of Medicine in 1946. He served his internship at Cook County Hospital in Chicago, and before going to Huntingburg was a surgical resident at the Jackson Clinic at Madison, Wisconsin.

Dr. George H. Belshaw has sold his office in Fairmount to Dr. Dale King, of Ridgeville. After his two years of practice in Fairmount, Doctor Belshaw has entered Methodist Hospital in Indianapolis, for a two-year residency in obstetrics and gynecology. Both Doctor Belshaw and Doctor King are graduates of Indiana University School of Medicine.

Formerly located in Indianapolis in the practice of internal medicine, Dr. Floyd Boys is now in Urbana, Illinois, where he has accepted a position as associate professor of health education. He is a 1932 graduate of Northwestern University School of Medicine.

Dr. Herbert P. Friedman, who has just completed a four-year residency in pathology at Indianapolis General Hospital, is now associated with the Carle Clinic in Urbana, Illinois, as pathologist and director of the laboratory. He is a 1941 graduate of the University of Iowa, and spent four years in the Army, being separated with the rank of major.

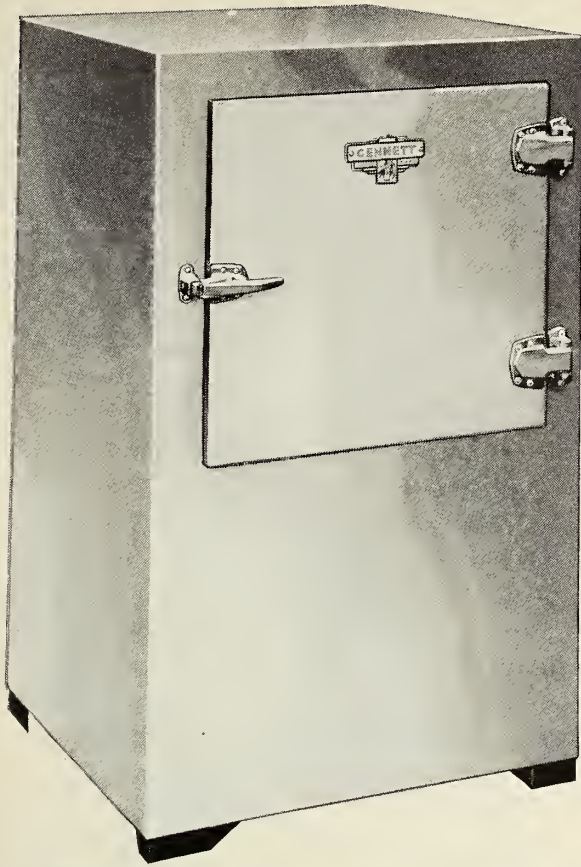
Dr. Clement E. Kelly, who has been in general practice in Indianapolis, has entered Indianapolis Methodist Hospital, to begin a residency in radiology. A 1944 graduate of Indiana University School of Medicine, Doctor Kelly spent more than two years in the Army.

Dr. George D. Davis became associated with the Mayo Clinic on July first, in a full time capacity in diagnostic radiology. Doctor Davis served for three years in the Army, and has just completed a residency at Methodist Hospital in Indianapolis. He is a 1938 graduate of the Indiana University School of Medicine.

A 1946 graduate of the Indiana University School of Medicine, Dr. Richard W. Dyke, of Indianapolis, began a residency at Indianapolis General Hospital on July first. He has just been separated from the Army, after two years of service.

A veteran of three years' service in the Army, Dr. Joseph D. Howell has become associated with Dr. Bennett Kraft, at 760 Bankers Trust Building, in Indianapolis, in the practice of allergy and internal medicine. Doctor Howell is a 1942 graduate of the St. Louis University School of Medicine, and has just finished his residency in medicine at Indianapolis General Hospital.

At the completion of his residency at Indianapolis General Hospital, Dr. Carlyle B. Slabaugh, of Indianapolis, will establish an office for the practice of ophthalmology at 1731 Brownlee Street, Corpus Christi, Texas. He is a 1941 graduate of the Indiana University School of Medicine, and a veteran of six years of service in the Navy.



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Dr. William Kerrigan has taken over the practice of Dr. John E. Mackey, of Rockport. A graduate of Indiana University School of Medicine, Doctor Kerrigan has just completed a residency at St. Mary's Hospital in Evansville. Doctor Mackey will complete his graduate work in obstetrics and gynecology at Indianapolis General Hospital.

Dr. C. A. Wiethoff, of Indianapolis, has become associated in the practice of general surgery with Drs. Frank Ramsey and Jack Pilcher, at 201 Hume Mansur Building, in Indianapolis. Following his release from service with the United States Navy, in 1946, Doctor Wiethoff completed a one-year residency in pathology at the Indiana University Medical Center, and for the past two years has been resident in general surgery at Indianapolis General Hospital.

Dr. Lester D. Bibler, of Indianapolis, was elected vice-chairman of the Section on General Practice of the American Medical Association at the annual session in Atlantic City in June.

Dr. William H. Davis began the practice of medicine on July first as an associate of Dr. J. William Herr, in Mount Vernon. A graduate of Indiana University School of Medicine in 1946, Doctor Davis was commissioned in the Naval Medical Corps Reserve and served internship at the St. Joseph hospital in South Bend. Following that he served on the *USS President Harrison* and at the Naval Hospital at Oakland, California.

Dr. Herbert S. Gaskill has been appointed professor of psychiatry on the staff of the Indiana University School of Medicine. Doctor Gaskill was an associate in psychiatry and medicine at the University of Pennsylvania, and was a member of the psychiatric department of that university's hospitals.

Dr. Joseph W. King, of Anderson, recently completed three years of graduate and residency training in otorhinolaryngology at Kingsbridge Veterans Hospital, Bronx, New York, and is now associated with his father, Dr. B. A. King, at 267 Citizens Bank Building, in Anderson, in the practice of otolaryngology.

Dr. Tracy O'Brien has established an office for the general practice of medicine in Clayton.

Dr. Paul S. Pentecost, of Richmond, is now resident in anesthesiology at Charity Hospital, in New Orleans. He is a graduate of Indiana University School of Medicine, and he served with the Army Medical Corps during World War II.

Dr. Robert B. Acker, of South Bend, has been appointed chief of staff of the new Northern Indiana Crippled Children's Hospital by Governor Schricker. Doctor Acker was one of the leaders in the campaign for construction of the hospital.

CHASE S. OSBORN MEMORIAL

The Huntington County Medical Society has erected a memorial tablet at a Huntington County homestead which was the birthplace of Chase S. Osborn, former Governor of the State of Michigan.

Governor Osborn's parents were both physicians and lived on the Huntington County farm as early as 1850. There young Osborn was born on January 22, 1860. Later he became one of Michigan's most distinguished citizens. Besides his political career, which was characterized by his exceedingly high ideals, he was famous as an orator, author, explorer, and naturalist. He died this year of pneumonia at the age of 89.

The dedication ceremonies were held on June 28, and were attended by the Hon. G. Mennen Williams, Governor of Michigan, and by the Hon. Henry F. Schricker, Governor of Indiana.

TO HEAD MILITARY MEDICINE

The appointment of Dr. Raymond B. Allen to the important post of Director of Medical Services for the National Military Establishment has been announced by Secretary of Defense Louis Johnson. This division will coordinate operations of the medical services of the three military departments, Army, Navy and Air Force, and related agencies of the National Military Establishment.

Doctor Allen, physician-president of the University of Washington, will serve for three months, beginning July 1, after which he will be succeeded by the Deputy Director, Dr. Richard L. Meiling of the medical faculty of Ohio State University.

EXAMINATIONS FOR APPOINTMENT IN THE MEDICAL CORPS OF THE U. S. NAVY TO BE HELD SEPTEMBER 12-16, 1949

The Bureau of Medicine and Surgery, Navy Department, has announced that examinations for the selection of candidates for appointment to the grade of Lieutenant (junior grade) in the Medical Corps of the U. S. Navy will be conducted at all United States Naval Hospitals during the period September 12 to 16, 1949 inclusive.

Graduates of approved medical schools in the United States or Canada who have completed intern training in accredited hospitals or who will complete such training within four months of the date of the examination and who are physically and in other respects qualified, may be examined for appointment as lieutenant (junior grade) in the Medical Corps of the Navy. Candidates must be less than 32 years of age at the time of appointment.

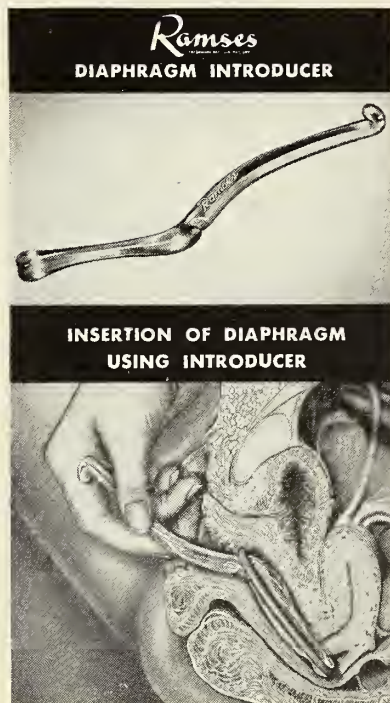
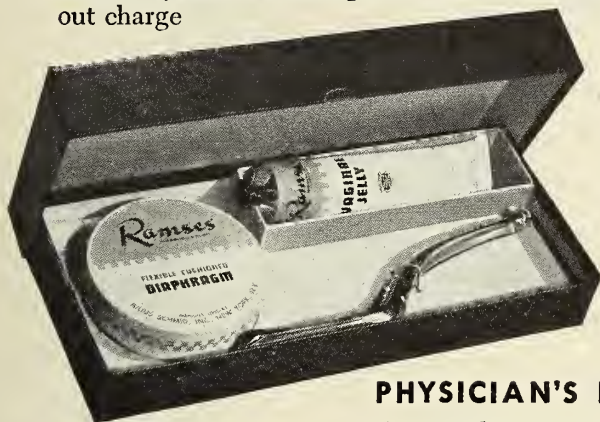
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Dr. John E. Wyttenbach, of Indianapolis, has been appointed as a member of the State Board of Beauty Culturist Examiners by Governor Schricker.

AIR FORCE MEDICAL RESERVE IS ESTABLISHED

General Hoyt S. Vandenberg, Chief of Staff, U. S. Air Force, announced that applications are being received for commissions in the newly created Air Force Medical Reserve. Physicians, dentists, nurses, and other medical personnel who served with the Army Air Forces during the war may make application through the Air Adjutant General, U. S. Air Force, in Washington.

AIR FORCE MEDICAL SERVICE IS ESTABLISHED

General Hoyt S. Vandenberg, Chief of Staff, United States Air Force, has announced the organization of a United States Air Force Medical Service.

The new Air Force medical service will provide better flexibility and control for Air Force medical services and requirements, and will provide more efficient and equitable coordination under unification of control within the National Military Establishment. No duplication will exist under the new organization since the Air Force previously had a medical service which, however, was under Army control.

Major General Malcolm C. Grow, Surgeon General of the U. S. Air Force, has been elevated to an organizational and functional position directly under the Chief of Staff, U. S. Air Force. This same organizational pattern will be maintained throughout the Air Force.

General Vandenberg emphasized the great career opportunities that exist in the newly created U. S. Air Force Medical Service and announced that Air Force plans are designed to correct the major objections of professional people to a career in the Armed Forces. Toward this end, housing will be made available for medical officers and their families at all Air Bases where such facilities exist.

Air Force doctors and other medical specialists are assured of opportunities for advanced training in both clinical medicine and research in aviation medicine. Professional facilities of general hospitals and laboratories, approved civilian institutions, and Air Force facilities will be used to provide regularly spaced training tours for members of the Air Force Medical Service. The Air Force will participate in joint staffing of selected Armed Forces general hospitals and laboratories.

Medical officers of the United States Air Force will be given every possible opportunity to pursue their specialty.

Doctors and dentists on duty with the U. S. Air Force will continue to receive the extra \$100.00 per month. In addition, a percentage of medical officers, nurses, and enlisted technicians who qualify for flying duties will receive additional hazard pay.

Dr. William A. Clunie, of Corydon, has opened an office for the practice of medicine in Huntington. He recently completed special training at the Eye, Ear, Nose and Throat Hospital in Chicago.

Dr. Raymond C. Beeler's office, at 712 Hume Mansur Building, Indianapolis, will be closed for vacation from August 8 to August 29.

The American Congress of Physical Medicine will hold its twenty-seventh annual scientific and clinical session September 6, 7, 8, 9 and 10, 1949 inclusive, at the Netherland Plaza Hotel, Cincinnati, Ohio. Scientific and clinical sessions will be given on the days of September 6, 7, 8, 9 and 10, 1949. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 6, 7, 8 and 9. These courses will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapy technicians who are registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

The International College of Surgeons, United States Chapter, will hold its fourteenth Annual Assembly and Convocation in Atlantic City, New Jersey, November 7, 8, 9, 10, 11, 12, 1949. David B. Allman, M.D., Atlantic City, is chairman of the Assembly.

The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery, as well as special surgical clinics held in Philadelphia hospitals on November 7. In addition, an extensive technical and scientific exhibit will be presented by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals and others. Special entertainment for the doctors' ladies has been planned.

Arnold S. Jackson, M.D., Secretary of the United States Chapter, has reported from Madison, Wisconsin, that over 500 surgeons will be received as Associates and Fellows of the International College at the Convocation to be held in Convention Hall, Atlantic City, on November 10.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M.D., Secretary, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, contact E. D. Parrish, Haddon Hall, Atlantic City, New Jersey.



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Announcement was made recently by **Dr. John L. Housley** that he has opened an office in Churubusco for the practice of medicine. He has been resident physician at the Fort Wayne Bible Institute for the past year. Before going to Fort Wayne, Doctor Housley practiced medicine in Akron, Ohio, for fifteen years.

Dr. F. K. Daugherty has returned to Wabash from Cincinnati, where he interned for the last year in Christ's Hospital. He will be associated with **Dr. R. M. LaSalle**, in Wabash. Doctor Daugherty is a graduate of Indiana University School of Medicine.

Dr. James H. Stygall, Indianapolis, was re-elected as a member of the Executive Council of the American College of Chest Physicians at the Fifteenth Annual Meeting held in Atlantic City, New Jersey, June 2-5, 1949. **Dr. Jerome V. Pace**, of New Albany, was elected Governor of the College for the State of Indiana for a term of three years.

BREAST CANCER MOVIE

A movie to show women the basic facts about breast cancer, including a simple technique for periodic self-inspection of the breasts, will be produced with a National Cancer Institute grant to the American Cancer Society.

Intended for women's clubs and organizations, the film is to be a joint production of the National Cancer Institute and the American Cancer Society. An animated color film designed for small projectors, it will run for ten minutes, and is part of a public information campaign that will include pamphlets and other explanatory materials.

FELLOWSHIP IN INDUSTRIAL MEDICINE

The University of Cincinnati announces the creation of a Texaco Fellowship in Industrial Medicine, through a grant made to the Institute of Industrial Health in the Graduate School of Arts and Sciences by The Texas Company. This fellowship is being established in the University and the Institute, in connection with the training of physicians for practice in Industrial Medicine and Hygiene.

The Texaco Fellowship will be awarded for a two-year period, to begin July 1, 1949, and will provide for the intramural period of training of the successful candidate. On the completion of the work of the fellowship within the University, an additional year will be spent in supervised practice in one or more industrial organizations. Upon successful completion of the entire course of training the degree of Doctor of Industrial Medicine will be awarded by the University.

Candidates who are interested in this opportunity for training in the field of Industrial Medicine should write directly to **Dr. Robert A. Kehoe** at the University of Cincinnati.

GIFT OF 250 SUBSCRIPTIONS

Henry Schuman, publisher of the scholarly Quarterly, *Journal of the History of Medicine and Allied Sciences*, announces that **Mrs. Josiah C. Trent**, of Durham, North Carolina, is instituting an annual gift of 250 one-year subscriptions to the *Journal* to be allocated to all medical schools in the United States and Canada. Recipients are to be selected by the faculty from among those in the yearly graduating class who have shown an interest in the cultural aspects of medicine.

It is with the desire to keep active Doctor Trent's influence and to perpetuate the ideals that he expressed that **Mrs. Trent** makes her generous gift. Doctor Trent was a founder of the *Journal* and a member of its Board of Editors.

ADDITIONAL BENEFITS PROVIDED BY ARMY FOR MEDICAL OFFICERS

Medical and dental officers will be given priority of consideration in assignment of quarters and their families will be allowed to accompany them on overseas tours of foreign duty, the Department of Army has announced.

This policy takes cognizance of the fact that Army medical and dental officers, as a result of the present shortage of service medical and dental personnel, are required to be on duty more hours per day, in many cases, than is normal, as well as to perform more than normally arduous duties.

It was also announced that the Surgeon General will be placed directly under the Chief of Staff. This re-emphasizes and facilitates his direct access to the Secretary of the Army and to the Chief of Staff in order that these officials may be kept constantly informed on the critical medical situation. General **Omar N. Bradley**, Chief of Staff, said this same organizational pattern is being implemented throughout the Army so that all medical officers will have direct access to their respective commanders.

Orders allowing families of medical and dental personnel to travel with them have been issued to the field.

The policy is the latest step in a continuing campaign designed to relieve the critical shortage of medical and dental officers in the Army by making their careers and living conditions more attractive. Previous action in this direction includes: provision for an extra \$100 per month in pay for medical and dental officers, giving them every opportunity to pursue their specialties, assigning ranks on the basis of civilian accomplishment, and emphasizing stability of their assignments by making only an essential minimum number of transfers of these officers.

These policies were announced by General **Bradley** with the concurrence of **Gordon Gray**, Acting Secretary of the Army.



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Dr. Thurman B. Rice, Director of the School of Public Health, Indiana University School of Medicine, has been awarded the 1949 American Cancer Society Medallion for outstanding contribution to cancer control in Indiana. Doctor Rice is one of the pioneers in the cancer movement and has talked to numerous lay groups throughout the state on the subject. He is author of the biological text "March Against Cancer" which is used in more than half of the high schools in Indiana and in other states. As a vice-president of the Indiana Cancer Society, Inc., he heads the committee directing the broad and vigorous program of lay cancer education.

The annual meeting of the American Board of Obstetrics and Gynecology, Inc., was held in Chicago, Illinois, from May 8 to May 14, 1949, at which time 236 candidates were certified. New Bulletins, incorporating changes made at the recent meeting, are now available for distribution upon application and give details of all new regulations.

The next scheduled examination (Part I), written examination and review of case histories for all candidates will be held in various cities of the United States and Canada on Friday, February 3, 1950. Application may be made until November 5, 1949. Application forms and Bulletins are sent upon request made to American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

UNORDERED MERCHANDISE RACKET IS INCREASING

Since the war there has been a gradual resumption of the old "unordered merchandise" rackets. This is a method of merchandising employed by certain unscrupulous distributors who send through the mails various items of merchandise which have not been ordered by the recipient with the hope that it will be accepted and paid for. From current reports it would appear that the mails are being flooded with such activities and the operators are apparently finding enough suckers to give them a tidy profit.—*Better Business Bureau Bulletin*.

AMERICAN FOUNDATION FOR HIGH BLOOD PRESSURE TO MERGE WITH AMERICAN HEART ASSOCIATION

Preliminary steps for merging the American Foundation for High Blood Pressure with the American Heart Association have been approved by the boards of both groups, it has been announced by A. W. Robertson, Chairman of the Board of the American Heart Association.

The high blood pressure group will thus become a Section of the American Heart Association's Scientific Council and will be known as the Council for High Blood Pressure Research. Other Sections within the Association's Scientific Council now include the Section on Circulation and the American Council on Rheumatic Fever.

LUNG CANCER GRANTS

Factors in the human environment that may influence the development of lung cancer will be studied under a National Cancer Institute grant. This is one of 36 special cancer control project grants, totalling \$550,802, approved by Surgeon General Leonard A. Scheele, Public Health Service, following action by the National Advisory Cancer Council.

The respiratory cancer investigation, to be conducted by the California State Department of Public Health, will seek possible causal factors through employment history studies of some 500 lung cancer cases. Where the history of the patient indicates possible occupational exposure, follow-up studies will be made by qualified industrial hygiene engineers and chemists to discover the source of the suspected hazard and the feasibility of protective measures. This study is the sixth investigative project on environmental carcinogens aided by the National Cancer Institute, other aspects of this problem being under study in New York, Pennsylvania, Ohio, Colorado and New Jersey.

The search for an accurate cancer diagnostic test will be assisted by National Cancer Institute grants to the University of Tennessee College of Medicine and the University of Kansas Medical Center. Many laboratory tests for cancer have been reported. However, many of these have proven unreliable. The others, which may be of value, have not been sufficiently tested. Since early cancer, in many cases, is curable by surgery or radiation therapy, an accurate test for finding early cases would make possible a great reduction in cancer mortality, even without discovery of the long-sought cancer "cure." The purpose of these two projects will be to evaluate a number of reported cancer diagnostic tests and develop those which appear most promising. This work will be coordinated with a University of Washington project already under way with National Cancer Institute aid. Cancer tests to be studied at the three institutions include the recently reported Huggins iodoacetate index test, Black plasma coagulation tests, Black dye reduction test, cholinesterase test, Roffo neutral red test, Munro protective colloid test and Bendien colloidal vanadate test.

Efforts to discover other cancer diagnostic tests also received National Cancer Institute aid. These include work at the University of Washington on the preparation of suitable antigens for complement fixation tests; test investigations at the Medical College of Alabama; and continued research on the cytologic tests for cancer at the University of California under Dr. Herbert F. Traut who, with Dr. George Papanicolaou, pioneered in the development of this widely accepted technique for finding early uterine cancer.

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Deaths

Bonnelle W. Rhamy, M.D., of Fort Wayne, died suddenly at his home on May 26, at the age of seventy-four. He was the founder and directing head of the Fort Wayne Medical Laboratory, one of the founders of the Indiana State Pathological Association, and a charter member of the American Society of Clinical Pathologists. Doctor Rhamy was a graduate of the Fort Wayne College of Medicine, in 1898, the Rockefeller Institute for Medical Research, and the Army Medical School. He was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Charles Joseph Folz, M.D., of Evansville, died suddenly on June 16, at the age of fifty-three. A graduate of Indiana University School of Medicine in 1923, Doctor Folz had practiced in Evansville for twenty-seven years. He was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Walter Hays Baker, M.D., of South Bend, died on June 6, at the age of seventy-two. He was a graduate of the Indiana Medical College School of Medicine of Purdue University, in Indianapolis, in 1907. He had specialized in surgery. Doctor Baker was a member of the St. Joseph County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Edward D. Havens, M.D., of Cicero, died on May 30, after a long illness. He was seventy-three years of age. A native of Cicero, he had practiced there since his graduation from the Medical College of Indiana, in Indianapolis, in 1903. Doctor Havens was a veteran of World War I, and was a member of the Hamilton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Joseph Nelson Study, M.D., of Cambridge City, Wayne County's oldest physician, died on June 13, after a short illness. He was ninety-eight years of age. Doctor Study graduated from the Bellevue Hospital Medical College, in New York, in 1883, and had practiced in Hagerstown and Cambridge City until his retirement twenty-three years ago. He was an honorary member of the Wayne-Union County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

Augustus L. Marshall, M.D., of Indianapolis, died at his home on July 1. He was seventy-three years of age. Doctor Marshall was a graduate of the Medical College of Indiana, in Indianapolis, in 1905, and had practiced ophthalmology in Indianapolis for thirty-two years. He had retired in January of this year. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

Walter B. Christophel, M.D., retired physician of Mishawaka, died at his home on June 21, after an illness of three years. He was sixty-nine years of age. He graduated from Northwestern University Medical School, in Chicago, in 1909, and had practiced in Mishawaka until he retired, in 1939. Doctor Christophel was a member of the St. Joseph County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Burton W. Egan, M.D., retired physician of Logansport, died on June 30, at the age of seventy-two. A graduate of the Medical College of Indiana, in Indianapolis, in 1904, Doctor Egan had practiced in Logansport for thirty years. He was a member of the Cass County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

* * *

Romuald O. Ostrowski, M.D., of Hammond, died on June 3 at the age of sixty-eight. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association. Doctor Ostrowski graduated from the University of Illinois College of Medicine, in Chicago, in 1908.

* * *

Alfred W. Snedeker, M.D., medical superintendent of Richmond State Hospital since December 1947, died suddenly on June 29, at the age of fifty-one. He was a graduate of Cornell University Medical College, in New York, in 1924, and had been on the staff at Bellevue Hospital in New York, and had taught at Phipps Psychiatry Clinic and at Johns Hopkins University.

* * *

Joseph Chester Silvers, M.D., of Muncie, died on July 4, after a long illness. He was forty-seven years old. A graduate of Indiana University School of Medicine in 1926, he was a member of the Delaware-Blackford County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.



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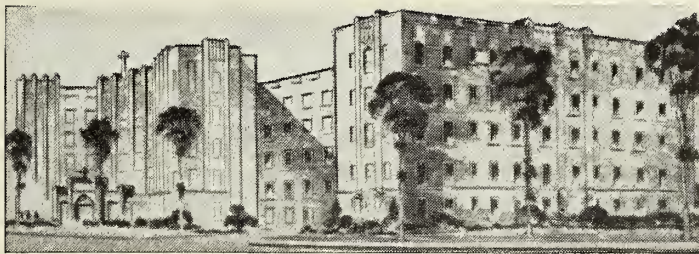
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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

June 25, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; Ray E. Smith, and J. A. Waggener.

Treasurer's Office

The treasurer of Mutual Medical Insurance, Inc., who is also treasurer of the state medical association, gave a report on the financial condition of the company.

Statements of receipts and expenditures for May for the association and *THE JOURNAL* were approved.

Membership Report

Number of members June 22, 1949-----	3,678*
Number of members June 22, 1948-----	3,604
Gain over last year-----	74
Number of members Dec. 31, 1948-----	3,688

* Includes 35 in military service (gratis), 188 honorary members.

Legislative Matters

National

The committee voted to take one one-year subscription to *The Washington Report on the Medical Sciences*.

Local

The executive secretary reported on a meeting held by the Committee on Public Policy and Legislation to discuss future policy regarding cult legislation.

Prepayment Medical Care Insurance

(1) Noel Hams, a member of the Executive Committee of the Indianapolis Accident and Health Association, discussed the relationship of the Blue Cross-Blue Shield plans and commercial companies selling health and accident insurance. He spoke for a better understanding between the two groups, pointing out that both are mutually interested in defeating socialized medicine.

(2) It was called to the attention of the committee that Indiana University proposes to buy hospital and medical insurance for its employees, and the Blue Cross and Blue Shield plans are bidding for the business.

1949 Annual Session, Indianapolis, September 26-29, 1949

Technical exhibit:

Requests for exhibit space. On motion of Drs. Black and Hauss, the committee approved the request of the A. H. Robins Company, Richmond, Virginia, to exhibit.

On motion of Drs. Black and Portteus, the Chicago Pharmacal Company was granted permission to exhibit only its Council accepted products.

Bronze plaque for president. The executive secretary was to ascertain the cost and present a sketch of a bronze plaque which would be appropriate to present to the retiring president, at the next meeting.

General practitioner award. The committee decided to purchase a \$50.00 painting for presentation to the "Family Doctor of the Year," on motion of Drs. Portteus and Black, and the treasurer was designated as the one to make the purchase.

Invitation to out-of-state guests. The suggested invitation to be sent to out-of-state guests was approved on motion of Drs. Portteus and Black, and the president and executive secretary were empowered to prepare a list of persons to whom the invitation is to be sent.

The field secretary gave a report on plans to use billboards and store window cards showing the Fildes picture, the Riley poem entitled "The Doctor" and a welcome greeting, for the duration of the annual session.

Entertainment program. The chairman of the Committee on Arrangements gave a report on the status of the entertainment program for the annual session. The committee approved spending up to \$1,500.00 for a state-wide radio network, to carry thirty minutes of the Baltimore and Ohio Glee Club concert on Tuesday night, September 27, and designated the president as the one to speak for a few minutes during the broadcast.

Dr. William R. Davidson of Evansville was selected to give the response in behalf of the members of the Fifty-Year Club, on motion of Drs. Portteus and Hauss.

Indiana A.M.A. Campaign Coordinating Committee

The field secretary gave a comprehensive report on activities in this field.

Organization Matters

Diabetes survey. The executive secretary explained the proposed diabetes survey through the county medical societies being undertaken by the Committee on Diabetes. On motion of Drs. Hauss and Black, the Executive Committee ordered a letter to be mailed to the chairman of the committee commending this project.

Vanderburgh county relief situation. The committee decided that it had no jurisdiction over the proposed contract of the Vanderburgh County Medical Society with the Vanderburgh County Department of Public Welfare for taking care of persons on old age assistance in Evansville hospitals for a flat \$300.00 per month.

Dr. C. S. Black, chairman of a committee which advises with the Indiana Department of Public Welfare on questionable bills presented for professional services, explained that the new ruling of the State Department requiring physicians to reveal the contents of prescriptions and the amount of medicine prescribed is due to abuses by a very few physicians. He explained that pharmacists had likewise presented exorbitant bills, and the department had taken this step in order to curb these practices. The committee agreed that it could not do anything to alter this situation.

On motion of Drs. Hauss and Black, the chairman of the Committee on School Health and Physical Education and the executive secretary were selected as delegates from the Indiana State Medical Association to the Second National Conference on Physicians and Schools, sponsored by the Bureau of Health Education of the A. M. A., to be held at Highland Park, Illinois, October 13 to 15, 1949.

The committee voted to pay the expenses of the women, invited to the Woman's Auxiliary-Executive Committee meeting on Sunday, June 26, on motion of Drs. Black and Portteus.

On motion of Drs. Portteus and Black, the attorney was instructed to write the president and former president of the Third District Medical Society in regard to the disputed election of councilor at its district meeting on May 25, 1949, pointing out the parliamentary rules.

Dinner for the press. The committee, on motion of Drs. Hauss and Portteus, approved the holding of a dinner for the press at the Columbia Club a week before the state meeting, as recommended by the Committee on Public Relations.

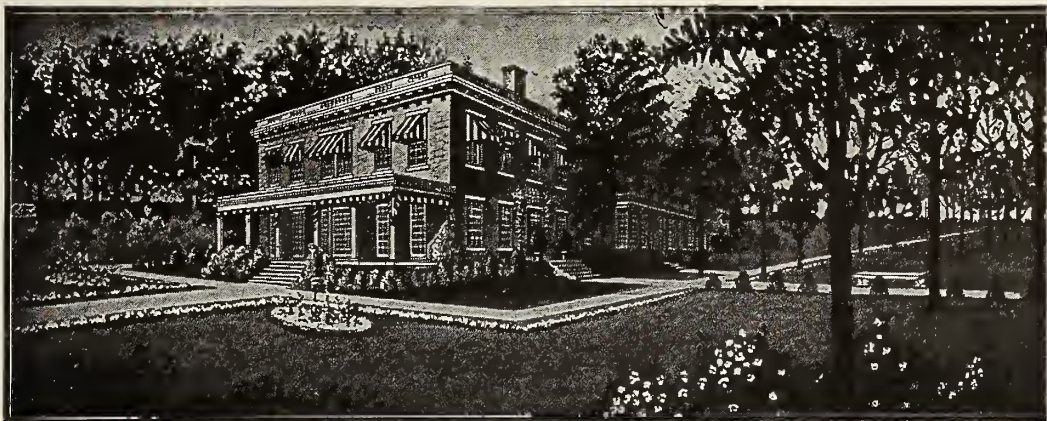
Invitation to hold annual session in Michigan City. The executive secretary was instructed to reply to a letter from the Michigan City Chamber of Commerce, pointing out the facilities required for a state meeting

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and stating that, if Michigan City can meet these specifications, its invitation to hold the 1951 annual session there will be presented to the delegates.

Dr. Portteus proposed that the committee present to the House of Delegates a plan for creating machinery for handling patient-physician grievances. He was asked to present some workable plan to the committee at its next meeting.

The Journal

Report on advertising:

Increases to June 25, 1949-----	\$ 953.80
Decreases -----	36.00

Total increase for month-----	\$ 917.80
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Total increase for year-----	\$3,100.10
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There being no further business, the committee adjourned to meet again at 6:30 p.m., Saturday night, July 30.

COMMITTEE ON PUBLICITY

May 20, 1949

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of June 20, 1949—"Childbirth Recovery."

Week of June 27, 1949—"Teething Time."

Week of July 4, 1949—"Chickenpox."

Week of July 11, 1949—"Body Compensation."

Week of July 18, 1949—"Farm Safety."

A news story for release June 1, 1949, entitled, "Hoosier Doctors on A.M.A. Program at Atlantic City," was approved.

A news release on the meeting of the Fifth District Medical Society at Brazil on May 25, 1949, was approved.

The committee approved a special article entitled, "The Licensed Nursing Home and the Physician," written by the executive secretary for use in the *Indiana Licensed Nursing Home News*.

The executive secretary announced that fifty-seven county societies had reported to date on whether or not they provide round-the-clock medical services. He was directed to prepare a news release on the result of the survey.

The fact that only three societies reported they would use radio transcriptions against compulsory health insurance, if provided with them by the committee, brought a decision to drop the project because of the prohibitive cost for such a small number. The executive secretary was instructed to notify the interested county societies.

COMMITTEE ON PUBLICITY

June 17, 1949

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and J. A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of July 25, 1949—"Automobile Safety."

Week of August 1, 1949—"Varicose Veins."

Week of August 8, 1949—"The Larynx."

Scripts of two radio addresses, by Senators Cain and Ellender, against compulsory sickness insurance were read by the field secretary. The committee directed him to send copies of the scripts to all county society secretaries, if Whitaker & Baxter can supply them.

The secretary presented a series of articles on the administration's compulsory sickness health bill, prepared by Wray E. Fleming, general counsel of the Hoosier State Press Association, which were mailed to the 217 member papers.

COUNCILOR DISTRICT MEETING

NINTH DISTRICT

The Ninth Councilor District meeting was held at the Moose Lodge, in Tipton, on May 25. The day began with a golf tournament, with a nice turnout of doctors participating. All were awarded prizes.

Luncheon was served for the ladies at the Christian Church in Tipton, which was followed by bridge, golf, or a movie, to complete the afternoon.

Dr. Wemple Dodds, of Crawfordsville, was re-elected Councilor of the Ninth District for another three-year term. Benton County will be host to the meeting for 1950.

The scientific session was held at the Elk's Home, consisting of the following program: Dr. William M. Dugan, of Indianapolis, spoke on "Salt Free Diet in Cardiac Patients"; Dr. Charles O. McCormick, Jr., of Indianapolis, discussed "The Sterility Problem in General Practice"; and Dr. Russell Hippensteel, of Indianapolis, discussed "Pediatrics in General Practice."

A banquet was held in the evening, at the Moose Lodge, to which more than ninety laymen from all over the county were invited. Guest speaker was Mr. Albert Stump, association attorney, who spoke on "Pills and Politics."

LOCAL SOCIETY REPORTS

COUNTY MEDICAL SOCIETY OFFICERS

JEFFERSON COUNTY MEDICAL SOCIETY

President, Allen P. Petway, Madison,

Vice-President, Lewis Jolly, Madison,

Secretary-Treasurer, O. A. Turner, Madison.

Dearborn-Ohio County Medical Society members met in Lawrenceburg, on June 17. Two case reports were presented: "The Treatment of Rocky Mountain Spotted Fever with Chlormycetin," by Dr. L. M. Baker, of Aurora, and "The Treatment of Acute Brucellosis with Chlormycetin," by Dr. G. A. Vail, of Lawrenceburg.

LaPorte County Medical Society members held a meeting at the Sheridan Beach Hotel, in Michigan City, on May 19. Thirty-two members were present, to hear Dr. August F. Daro, of Chicago, speak on "Recent Trends in Obstetrics."

Morgan County Medical Society members met at Morgan County Memorial Hospital, in Martinsville, on July 7. Dr. George M. Brother, of Indianapolis, spoke on "Suggestions on School Health Immunization." Eight members and one guest were present.

Orange County Medical Society members met at West Baden, on June 8. Twelve members were present. The guest speaker was Dr. Carlos A. Fish, Jr., of Louisville, Kentucky, who spoke on "Meningococcemia."

Vanderburgh County Medical Society members held their regular meeting at the Hotel McCurdy, in Evansville, on June 14. The guest speaker was Dr. Laman Gray, associate professor of obstetrics and gynecology at the University of Louisville School of Medicine. His subject was "Diseases of the Vulva, Vagina and Cervix." Ninety-seven members were present.



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President—Mrs. Truman Caylor, Bluffton.

President-elect—Mrs. D. E. Lybrook, Galveston.

Corresponding Secretary—Mrs. Harry Harvey, Fort Wayne.

Recording Secretary—Mrs. Bert Ellis, Indianapolis.

Treasurer—Mrs. Wendell Kelley, Anderson.

Press and Publicity—Mrs. Claude S. Black, Warren.

**PRESIDENT'S REPORT OF THE NATIONAL CON-
VENTION OF THE WOMAN'S AUXILIARY TO
THE AMERICAN MEDICAL ASSOCIATION**
Atlantic City, New Jersey

The twenty-sixth annual convention of the Woman's Auxiliary to the American Medical Association met in Atlantic City, June 6 to 10, concurrent to the 98th annual meeting of the American Medical Association.

At the formal opening of the Auxiliary convention on Tuesday, Mrs. Luther H. Kice, national president, presided. Mrs. Kice, as principal speaker of the morning, delivered the annual president's message to the American Medical Association Auxiliary. She pointed out the extreme importance of the Auxiliary's work in informing other women's organizations of the latent dangers of political medicine advocated by the Murray-Dingell bill. Warning that American medicine is engaged in a life and death struggle for existence, Mrs. Kice urged us, as Auxiliary members, to enlist the aid of every woman's organization, both large and small, in the fight against its downfall. Herein lies the keynote of the convention—the "coordination of our efforts" in combating our common problems.

Round table discussions were held both on Tuesday and Wednesday by the respective national committee chairmen on program planning, public relations, legislation, and "Hygeia." They, too, stressed the "coordination" of our overall program, the importance of dove-tailing local programs and state needs.

Following the election of the 1950 nominating committee, it was announced that Mrs. Kice and Mrs. George Turner will serve on the committee as the two national board members; and again this year Indiana is fortunate in being one of the five states represented on this committee. As president, I will represent our state, along with Mrs. Paul Craig, Pennsylvania, Mrs. E. Quayle, District of Columbia, Mrs. H. E. Cristenberry, Tennessee, and Mrs. Charles Waas, Minnesota.

The election of new officers and the installation of Mrs. David B. Allman of Atlantic City as national president high-lighted the Wednesday session. Mrs. Arthur A. Herold, Louisiana, who has been serving as national treasurer, will take the office of president-elect. Other officers elected are: Mrs. Harold F. Wahlquist, Minnesota, first vice president; Mrs. Henry Garnjost, Oregon, second vice president; Mrs. W. E. Hoffman, West Virginia, third vice president; Mrs. Harry M. Gilkey, Missouri, constitutional secretary; Mrs. George Turner, Texas, treasurer; Mrs. Ralph Eusden, California, Mrs. Scott C. Applewite, Texas, and Mrs. W. W. Potter, Tennessee, directors for two years.

This session also included a report from our immediate past president, Mrs. W. R. Morrison of Kokomo. Indiana may well be proud of its accomplish-

ments in legislation, radio, public relations, and organization. Seven new county organizations have been added this year, making a total of 47 organized counties and a membership of over 1900.

Indiana was entitled to 18 delegates and an equal number of alternates. Our official delegation was made up of Mrs. W. R. Morrison, Kokomo, Mrs. W. J. Stangle, Bloomington, Mrs. Frank Gastineau, Indianapolis, Mrs. Jack L. Eisaman, Bluffton, Mrs. Bernard R. Hall, Logansport, Mrs. Edward Pitken, Martinsville, Mrs. A. H. Griep, Evansville, Miss Lucy Schuler, Kokomo, Mrs. Wallace Tierman, Bluffton, Mrs. Lester D. Bibler, Indianapolis, Mrs. Thomas A. Cortese, Indianapolis, Mrs. Albert M. Donato, Indianapolis, Mrs. Jerome Pace, New Albany, Mrs. Wendell C. Kelly, Anderson, Mrs. James C. Katterjohn, Indianapolis, and Mrs. Stanley M. Casey, Huntington. The members of the Indiana delegation were faithful in attending meetings, for which I am truly grateful, and I am happy that during much of the time we were able to combine business and pleasure.

The social events on Monday, previous to the formal opening of the convention, were among the most pleasurable activities. The members of the Woman's Auxiliary of New Jersey were hostesses to the National Board of Directors, state presidents and presidents-elect, and all other guests at a tea given in honor of Mrs. Kice and Mrs. Allman. A novel feature of the afternoon were the orchids flown here from the Hawaiian delegation which were presented to each guest. That evening a fashion show was given at Convention Hall by the cotton industry.

Our luncheons were a mixture of business and pleasure. The Tuesday luncheon, honoring the past presidents of the A.M.A. Auxiliary, featured Miss Leone Baxter and Mr. Clem Whitaker, directors for the American Medical Association National Education campaign, as speakers. They re-emphasized the part which the Auxiliary rightfully plays in this planned campaign against socialization of medicine.

On Wednesday the Indiana delegates and alternates were entertained at an early morning breakfast, from which they went to the nine o'clock session in a body. At luncheon that day the Auxiliary had as speakers and guests several of the top officials of the A.M.A.: Dr. R. L. Sensenich, president, Dr. Ernest E. Irons, president-elect, Dr. Elmer L. Henderson, chairman of the Board of Trustees, Dr. J. J. Moore, treasurer of the A.M.A., Dr. George F. Lull, secretary and general manager, and Dr. Morris Fishbein, editor of the A.M.A. Journal and Hygeia. An announcement disclosed that 46 states, the District of Columbia and Hawaii were represented at these meetings of the Auxiliary to the American Medical Association, and a total membership was reported of over 48,000.

Thursday's meetings, banquet, and dance concluded the highly valuable and praiseworthy 1949 convention. Although no open sessions were held on the final day, there was a meeting of the Board of Directors, with Mrs. Allman, newly installed president, presiding. Following this was a conference attended by the president, president-elect, national officers, chairmen of standing committees, state presidents and presidents-elect. The purpose of this conference was to discuss the projects of the coming year and to "coordinate our efforts" in an attempt to eliminate the needless and wasteful overlapping in the work of the standing committees. It was also pointed out that it is imperative for every Auxiliary to become fully acquainted with the American Medical Association's 12-point health program, which we had accepted at an earlier meeting as a part of our program of activities. Finally, we reviewed the many measures which we can take to help the medical profession defend its stand against socialized medicine, the foot in the door to national socialism, the threat to the American way of life.

—Julia G. Caylor, State President.

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THE TREATMENT OF THORACIC AND ABDOMINAL ANEURYSMS OF SYPHILITIC AND ARTERIOSCLEROTIC ORIGIN

(PRELIMINARY REPORT)*

J. K. BERMAN, M.D.

FOSTER J. BOYD, JR., M.D.†

WM. K. SAINT, M.D.**

INDIANAPOLIS

I. OCCLUSION OF THE VESSEL PROXIMAL OR DISTAL TO THE ANEURYSM

EARLY efforts to control the rapid enlargement of arteriosclerotic and syphilitic aneurysms of the abdominal aorta were patterned after the work of Aëtyllus in the Second Century, who advocated proximal and distal ligation; and John Hunter who practiced proximal ligation at a distance. Thus the method which occupied the attention of surgeons was that of proximal or distal ligation, or both. Ligatures, tapes, tubes, clamps and snares were fastened around the vessel and allowed to protrude from the abdomen. They usually cut through or became secondarily infected until Halsted introduced his aluminum band. Even

this method caused necrosis of the vessel wall and subsequent hemorrhage. Later rubber bands were used but they also eroded through the arterial wall. External compression of the vessel proximal to the aneurysm was then induced by other methods with the hope of causing perivascular fibrosis. Among these may be listed: (1) wrapping the vessel with strips of fascia, cellophane, cotton, silk, catgut strips; (2) injecting irritating but not destructive solutions in the vessel wall, such as acriflavine, silica, iodine, silver nitrate. These were unsuccessful.¹

Since external compression did not solve the problem, intrinsic contracture of the vessel wall was attempted by the use of plication sutures; injection of irritants into the wall such as sodium morrhuate; painting the outer wall after denudation with iodine, silver nitrate or acriflavine; and injury by diathermy. All of these methods were disappointing.

Intravascular occlusion proximal to the aneurysm by fascial plugs, constricting clamp with prongs, and irritating solutions such as 50 percent glucose or sodium morrhuate also failed to arrest the progress of the lesion.

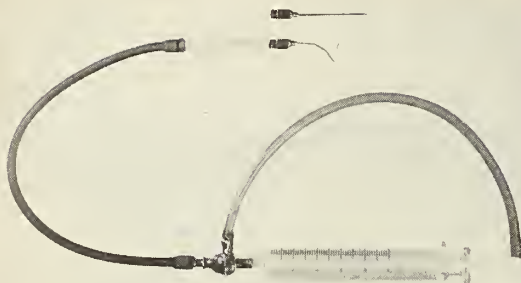
* From the Chas. J. Wolf Foundation for Medical Research and the Department of Surgery, Indianapolis General Hospital.

† Research fellow of Chas. J. Wolf Foundation 1948-1949. Resident in Surgery, Indianapolis General Hospital.

** Research fellow of the Chas. J. Wolf Foundation.

We are greatly indebted to Mr. Roland Parker, A.B., of the Eli Lilly Research Laboratories for many helpful suggestions.

Figure I



Apparatus employed for injection of various substances around the aorta to produce fibroplasia. Since this photograph was made we have fashioned various shapes of needles for human use. The needles should be about #18 gauge, blunt, and have a short bevel.

II. OBLITERATION OF THE ANEURYSM

First efforts to obliterate an aneurysm by the production of clotting appeared in the Nineteenth Century and consisted of the introduction of small fragments of metal. Later silver or copper wire was introduced within the sac, and a galvanic current was passed to encourage thrombus formation. This method is still in use although electricity is not often employed; it is used more often in the saccular type rather than the fusiform variety of aneurysm. The method is often followed by leakage around the point of the wire in the aneurysm wall and may result in fatal hemorrhage. The operation of Matas (endoaneurysmorrhaphy) has been used in aneurysms of the aorta of traumatic origin with success. It has also been tried in syphilitic and arteriosclerotic types with less gratifying results.

III. FIBROSIS OF ANEURYSM WALL WITH GRADUAL CONSTRICTION

The methods which have been described as causing fibrosis and constriction proximal to the aneurysm cannot be used in the thin wall of an aneurysmal sac because they are too traumatizing and would cause a slough. Recently polythene film has been tried by Poppe and De Oliveira;² DeTakats and Reynolds;³ Abbott⁴ and others, based upon the work of Page⁵ in producing fibrosis around kidneys in his experiments on hypertension. Regular cellophane has been used on skin-grafted areas to prevent sticking of dressings and was selected because of its inert properties. Another variety of cellophane (polythene 1.5 mil type NV-7-14 DuPont) induces a great amount of fibrous proliferation and has been successfully employed in experimental animals and humans. This method requires that the mediastinal pleura or peritoneum be removed from the wall of the aneurysmal sac. Then the polythene is wrapped around the denuded area, and the overlying pleura or peritoneum is

Figure II



Dog Number 45

Photograph of abdominal aorta opened longitudinally. This segment was wrapped with polythene film (1.5 mil NV-7-14 DuPont) for thirty (30) days. Note periaortic fibrosis and narrowing of aortic lumen.

sutured. If this is not done, adjacent organs may also become involved in the fibrotic process unless the polythene is covered by fascia or inert cellophane (300 P. U. T. 71; or 300 P. T. 62, melt cast polythene type NV-7-16). In extremely large aneurysms with adhesions to the pleura or peritoneum and with thin areas present in the sac, attempts at denudation may be hazardous.

If the aneurysm could be "wrapped" with a substance inducing fibrous proliferation without the dangers of denudation then a simpler and safer method would be available for the treatment of large, thin-walled aneurysms. The best method seemed to be the injection of a fibrous tissue inciting substance which would: (1) be readily injectable, (2) remain liquid until it came into contact with the tissues, (3) would not traumatize or necrotize tissue or cause violent reactions, (4) would not be toxic when used in large amounts.

Yeager and Cowley⁶ have shown that it is the dicetyl phosphate in solvent cast polythene (type NV-7-14) which is the reactive agent which causes fibrosis. Therefore a supply of polythene film and dicetyl phosphate in amorphous form was obtained from the E. I. DuPont De Nemours & Company and experiments were done on the thoracic and abdominal aortas of dogs.

EXPERIMENTAL STUDIES

1. 1.5 mil polythene film type NV-7-14 with dicetyl phosphate (DuPont).

This film contains dicetyl phosphate in an amount less than 1 percent. The dicetyl phosphate is present on one side only. Since the thickness of the flexible film is 15/10,000 of an inch the total quantity, though pure, is very small. This drug melts at 71-72° C. and therefore autoclaving or boiling the film would remove this fibrous

Figure III



Dog Number 45

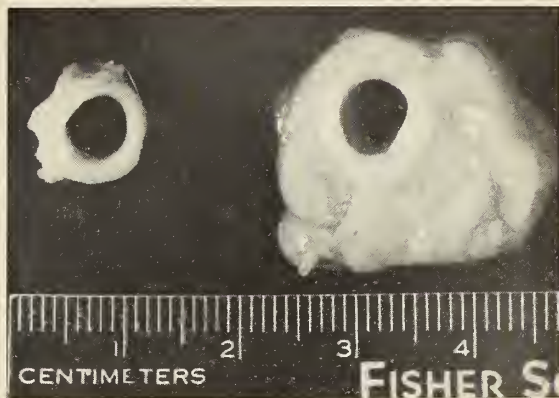
Photograph of thoracic aorta opened longitudinally thirty (30) days after periaortic injection of 0.5% dicetyl phosphate in olive oil. Note enormous thickening due to fibrosis at the aortic arch, also the narrowing which has occurred. The heart appears in the background.

tissue-producing substance. Also, handling or wiping the film removes some of the drug. Therefore chemical sterilization was used. In these experiments 50 percent ethyl alcohol was employed as the sterilizing agent. Ninety percent alcohol dissolves the dicetyl phosphate. A good fibrous tissue response was obtained from this film.

2. Dicetyl phosphate is a solid amorphous material. Its formula is $(\text{CH}_3(\text{CH}_2)_{14}\text{CH}_2\text{O})_2\text{HPO}_2$. It is the di-ester of cetyl alcohol and phosphoric acid and is soluble in toluene up to 4½ percent at room temperature, butyl ether and 90 percent ethyl alcohol. These solvents are too toxic and irritating to be used in the experimental animal or human.

Among the more common esters in everyday use is olive oil, which is an ester of oleic, palmitic and stearic acid. When sterilized in an autoclave at 120° C., olive oil will accept dicetyl phosphate into solutions up to 2 percent easily. We did not experiment with higher concentrations. Some cloudiness occurs on cooling and a precipitate slowly settles out. This may be redissolved by warming to body temperature.

Figure IV



Dog Number 48

Photograph of cross section of normal thoracic aorta (left) and cross section of thoracic aorta which had a periaortic injection of 0.9% dicetyl phosphate in olive oil 14 days previously. Note great amount of periaortic fibrosis, but as yet there is no narrowing of the lumen which occurs in about 30 days.

Using solutions of ½ percent and 0.9 percent, excellent results were obtained. Since olive oil is more quickly absorbed than dicetyl phosphate this substance is allowed to act in pure form. A 0.9 percent solution is probably the best concentration in the human.

METHODS USED IN INJECTING DICETYL PHOSPHATE IN OLIVE OIL

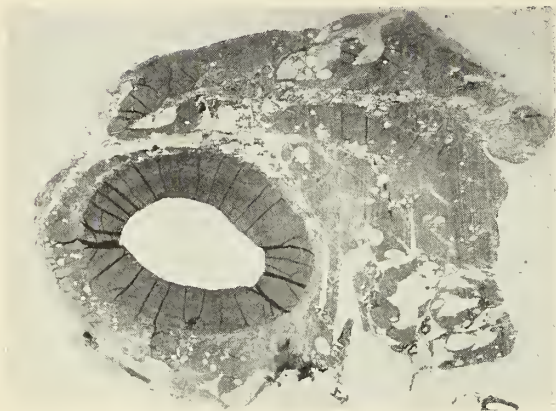
The mixture was heated and injected beneath the pleura and peritoneum around the thoracic and abdominal aortas in groups of dogs. Figure 1 shows the syringe, tube and needles employed. The curved needle is useful for the posterior injection. The size of the curve varies with the size of the aneurysm and therefore various sizes will be necessary. A number 18 needle with a blunted bevel is ideal. The tube is necessary because the needle must be held steady, due to the pulsation, while the

Figure V



Cross section of normal aorta.
(Low power photomicrograph x9.)

Figure VI



Cross section of aorta which had injection of 0.9% dicetyl phosphate in olive oil around its circumference fourteen (14) days previously. Note the enormous amount of fibroplasia around the aorta. There has, as yet, not occurred a great amount of narrowing of the aortic lumen.

assistant injects the solution. Moreover, if the tube is long enough possible leaks into the pleural or peritoneal cavities are more easily averted. Extravasation of the solution proximal and distal to the site of injection beneath the pleura or peritoneum is easily prevented by manual pressure for a few minutes or by firm packing. After the injection a small piece of gelfoam is placed over the small puncture wound. The ease of administration in the human was determined by experiments on fresh postmortem specimens.

OTHER SOLUTIONS AND SUSPENSIONS USED

Using the above technique, we employed other fibrous tissue-producing substances. In several animals various sections of the thoracic or abdominal aorta were injected with different materials, viz.: aerosol, liquid latex, licopodium, mineral oil, flexible collodian, negatan (negatol, Lilly).

Figure VII



Section made through a subcutaneous area of fibrosis which was the result of placing a minute quantity of dicetyl phosphate powder beneath the skin.

Some of these were unsuitable, others have possibilities.

AEROSOL O. T. (American Cyanamid and Chemical Co.) is a detergent related to soaps. Although all airborne suspensions of minute solid or liquid particles are classed as aerosols this is a special type. It is dioctyl sodium sulfosuccinate. We used it in a solution of 0.154 percent in physiological saline. Results were very good and no toxic symptoms occurred.

LIQUID LATEX was not satisfactory.

LICOPodium spores in suspension, so as to make one million spores per cc., was used without good results.

MINERAL OIL was also not suitable, producing little reaction.

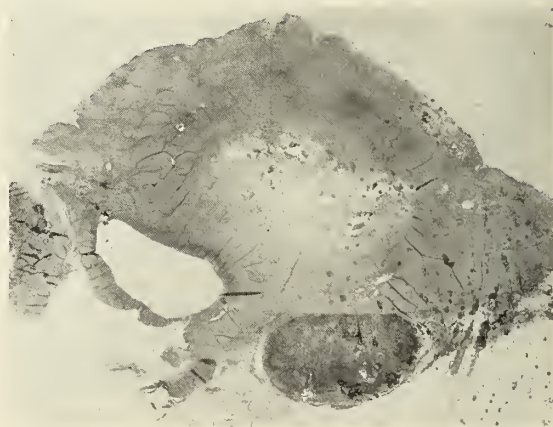
FLEXIBLE COLLODIAN (U. S. P. XI) is made of 4 percent pyroxylin (a nitro-cellulose), 2 percent camphor, 3 percent Oleum Ricini (castor oil), 67 percent ether and 22 percent alcohol. It hardens almost as fast as injected. The objections to this material are: (1) It forms a hard inflexible band around the vessel; (2) Pulsations against this substance are apt to cause erosions with perforation. In other words, it has the same objections as metal bands.

NEGATAN (Negatol, Lilly) is an aqueous solution of 100 grams containing 45-49 grams negatan (a condensation product obtained by reacting meta-cresol-sulfonic acid with formaldehyde). This product was found to be highly toxic when injected in solutions of more than $\frac{1}{4}$ strength in physiological saline. The immediate reaction is one of a sclerosing agent. There is much necrosis of tissue. However, fibrosis is minimal.

SUMMARY AND CONCLUSIONS

Dicetyl phosphate 0.9 percent in olive oil is an ideal solution for the production of fibroplasia. This is a preliminary report of its use in experimental

Figure VIII



Abdominal aorta cross section showing fibrosis engendered by solution of Negatan (Lilly) $\frac{1}{4}$ strength. Necrosis is present and other areas have almost the consistency of cartilage.

animals for the purpose of producing a gradual fibrosis and obliteration of large fusiform aneurysms which, unlike the rarer saccular variety, do not lend themselves so well to other forms of treatment. Even wrapping with polythene is incomplete and hazardous in the very large types because uncovering may release a weak spot in the wall which could be fatal.

Other vehicles than olive oil may be found which are more easily handled. Oleic acid, for example, when combined with glycerine (forming tri-oleic acid because glycerine combines with three molecules) is less viscid. We have not used this material as yet.

While this study was primarily intended for the treatment of aneurysms, other uses for dicetyl phosphate solution suggested themselves, such as: the production of gradual occlusion of the coronary arteries in the experimental study of coronary disease; injection around the portal vein to produce

experimental portal hypertension; around the kidney to cause ischemia; around the heart to produce constricting pericarditis.

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TREATMENT OF FRIEDLANDER'S PNEUMONIA WITH STREPTOMYCIN—REPORT OF A CASE

RALPH U. LESER, M.D.

ROBERT A. SWITZER, M.D.

DON G. BOCK, M.D.

M. E. GODBEY, M.D.

INDIANAPOLIS

THE treatment of pneumonia with sulfonamides and penicillin has been so successful in the majority of cases that it usually comes as a surprise and a shock to the physician when the occasional pneumonia fails to respond to treatment. Valuable time is frequently lost before physicians suspect and prove Friedlander's infection, and institute what is being regarded in a widening circle as the correct treatment. In some cases the true nature of this uncommon condition is not suspected, due to a lack of familiarity with this type of pneumonia and its therapy. For these reasons, a case of Friedlander's pneumonia successfully treated with streptomycin is being reported.

BACTERIOLOGY

The Friedlander's bacillus (*Klebsiella pneumoniae*) is a gram-negative rod, 0.5 to 5 microns in length and approximately half as wide. It may be long or coccoid in shape. It may occur singly or in short chains. It is nonmotile, nonspore-forming, aerobic and facultatively anaerobic. It has a distinct thick capsule, which is seen on direct smears. The organism grows readily in the usual laboratory media. The organism can be

recovered in pure culture by mouse inoculation or by culture of the sputum on blood agar plates.

Several distinct types have been identified by means of agglutination and animal protection tests. Julianelle¹ identified groups A, B, and C, as well as X, type specificity depending on capsular polysaccharides. The organism has a rather wide distribution, being found in the air, soil, and water. It also occurs as a saprophyte in the upper respiratory and intestinal tracts in a small percentage of human beings. Infections due to the bacillus may be conveniently divided into pulmonary and extrapulmonary groups.

PULMONARY INFECTIONS

The Friedlander's bacillus is responsible for approximately 1 to 3 percent of all pneumonias. It is often a severe pneumonia, but many cases are relatively mild, with fever below 101 degrees.² Involvement of several lobes is frequent. The sputum, although frequently brick red in color and a homogenous emulsion of blood and mucus, is, in a certain number of cases, mucoid or yellow and purulent. Bacteremia occurs in the majority of cases, and, if untreated, results in a mortality of

75 percent. The most frequent complications are abscess formation and empyema; meningitis and purulent pericarditis occur more rarely. The mortality in untreated cases is over 90 percent.² Solomon reported deaths in 97 percent of 32 cases receiving no chemotherapy.

EXTRAPULMONARY INFECTIONS

These have been described by Solomon.³ Intra-abdominal infections are usually secondary to perforative lesions of the large intestine, such as appendicitis, diverticulitis, and carcinoma. Abscess formation or generalized peritonitis may occur. Secondarily, subphrenic or liver abscess, and, occasionally, septicemia may result. Biliary tract infections usually occur in connection with cholelithiasis. Purulent otitis media and mastoiditis are not rare, and may lead to cavernous sinus thrombosis or meningitis. In general, extrapulmonary infections are attended by a relatively low mortality (17 to 30 percent). Solomon³ has reported three cases of wound infection with Friedlander's bacillus followed by meningitis in American soldiers. He felt that they represented cases of hospital infection, spread by droplet infection by the attending personnel. He suggests the wearing of masks and the observance of strict operating room technique when wounds are dressed. He advocates routine culture of all wounds, and believes that the bacillus would be found quite frequently if this were done. He states that this is infrequently done because gram-negative rods are passed off as coliform organisms.

BASIS FOR THERAPY

In 1945 Heilman⁴ demonstrated the protective effect of streptomycin for mice against organisms of the Friedlander group. Herrell and Nichols⁵ described two cases of Friedlander's pneumonia effectively treated by the intramuscular route and by nebulization. One was treated for seven days with 1,120,000 units, the other for ten days with 2,000,000 units. They stated that gram-positive organisms can be eradicated by the administration of penicillin by nebulization at the same time that gram-negative organisms are eliminated by streptomycin. Learner and Minnich⁶ reported a proven case of Friedlander's pneumonia which responded rapidly to streptomycin therapy after failure of penicillin to effect improvement. Miller⁷ reported a case of *Klebsiella pneumonia* in a newborn child which responded dramatically to streptomycin following failure of penicillin and sulfadiazine. Jacob and Top⁸ reported seven cases of Friedlander's meningitis with two recoveries, both treated with penicillin and sulfadiazine. They recommended combined administration of large doses of sulfadiazine, penicillin, and streptomycin in Friedlander's meningitis. According to their belief and that of investigators quoted by them, there is some sensitivity of the Friedlander bacillus to sulfonamides and penicillin. It is worthy of note that Herrell still believes that streptomycin has done more in

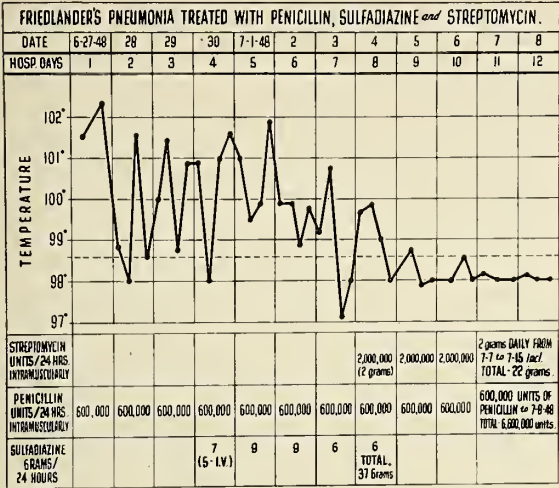
Friedlander's infection than any other antibiotic to date. He states that the only difficulty which has been encountered is that once in a while the organism will become extremely resistant to streptomycin even in a short period of time.

CASE REPORT

The patient, a 34 year old office worker, was first seen in the home on June 19, 1948, with complaints of cough, malaise, and fever, which rose to 101 and 102 degrees. Physical examination revealed a temperature of 99.4, pulse of 86, considerable photophobia and conjunctivitis, and a few loud rhonchi heard in the bases posteriorly. Treatment consisted of salicylates, codeine, one injection of penicillin intramuscularly, and 400,000 units of penicillin given orally in tablet form. After this visit, the senior author (R. U. L.) was absent from the city from June 20 to 27. She was seen at intervals by two physicians who later stated that her course during this week had been exceedingly stormy, with temperature elevations up to 104 and 105 degrees, and no response of any sort to penicillin. They felt that she probably represented a case of virus pneumonia. She was seen again by the senior author on June 27, and it was obvious that her condition had become much worse. She was admitted to the Methodist Hospital (Indianapolis) with a temperature of 102.4, a pulse of 110, and respirations of 28. There was a racking, nearly continuous, nonproductive cough, dyspnea, and considerable anxiety. Innumerable rales were heard in the left lung, anteriorly and posteriorly; there were also rales in the right lung, with the exception of the upper lobe. The roentgenogram of the chest was reported by Dr. Harold C. Ochsner on June 28 as follows: "There is a mottled infiltration throughout the entire left hemithorax and in the right upper. Conclusion: extensive atypical pneumonia, bilateral." (Figure 2.) Treatment consisted of penicillin given intramuscularly in a dosage of 300,000 units given twice daily (duracillin), meperidine (demerol), and methadon (dolophine). Sputum culture for the prevailing organism was requested, with a suggestion to the laboratory to search particularly for pneumococci, Friedlander's bacillus, and acid-fast bacilli, the latter because the patient's husband died of tuberculosis. It was not possible to obtain smear or culture at this time because of the nonproductive nature of the cough. In retrospect, it is felt that it would have been best to obtain some sputum by means of a throat swab. The temperature curve was septic in type, varying from 97.6 to 102.5 (Figure 1). The patient was regarded as being in critical condition.

Administration of sulfadiazine was begun on June 30, the first dose being administered intravenously in the amount of 5 grams. After the first day, when 7 grams were given, 1½ grams were given at four hour intervals. The cough was uncontrollable; codeine, demerol, and dolophine were supplanted by dilaudid and morphine, without ap-

Figure 1

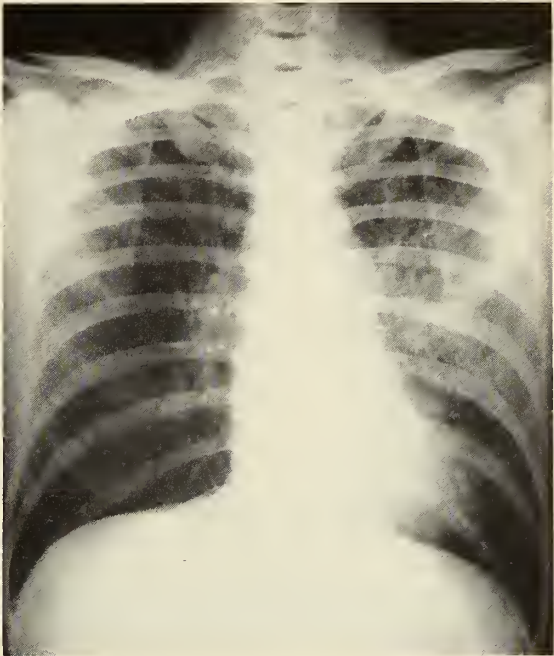


preciable relief. Anorexia and inanition were such that intravenous glucose, amino acids, and vitamin B complex were administered. Intravenous medication was poorly tolerated, and a high calorie diet with vitamins and amino acids were administered by nasal tube. A blood culture which had been taken on June 28 was reported by the laboratory of Dr. Horace M. Banks as yielding no growth. The final report of July 31 was the same. On July 3, a sputum specimen was finally obtained. The report of a direct smear stained by Gram's method was, "A few gram-positive cocci in groups and singly. Many gram-negative bacilli. Several forms resembling *Monilia* seen." Sputum was mucoid at times, at others purulent, never red.

By July 4 the patient's condition was still more unsatisfactory, despite the seeming betterment which a glance at the temperature curve would seem to indicate. It was regarded as hazardous to wait another 48 hours until the sputum culture would be completed, and administration of streptomycin was begun in a dosage of 2 grams daily, divided into 5 doses, given at 9 A.M., 12 noon, and at 3, 6, and 9 P.M. The first dose was administered at 9 A.M. of July 4, and by 4 P.M. the temperature was normal, to remain so for the remainder of her hospital stay. Roentgenogram of the chest on July 7: "There is a feathery infiltration in both lung fields, particularly at the left base, but the infiltration is greatly diminished in extent since the last examination. Conclusions: Atypical pneumonia, with improvement." (Figure 3.) In general, the clinical course paralleled the clearing of the roentgenological picture and defervescence. Whereas the patient had expressed the belief that she was going to die during the height of her illness, and had declared that she wished to, which was further reflected in her inability to eat, her mood rapidly changed to one of optimism.

On about July 15, a papular rash appeared on the medial surfaces of her thighs; it was not certain whether this was due to streptomycin or to

Figure 2



the heat. Treatment was symptomatic, with calomine lotion and phenol. Some tinnitus appeared on July 15, but this disappeared shortly after discontinuation of streptomycin. Dyspnea, cough, expectoration, malaise, and anorexia had all disappeared by July 17, and by the time of dismissal on July 19, the only remaining symptoms were weakness and fatigue; a few scattered rales in the left base constituted the only physical findings. Roentgeno-

Figure 3

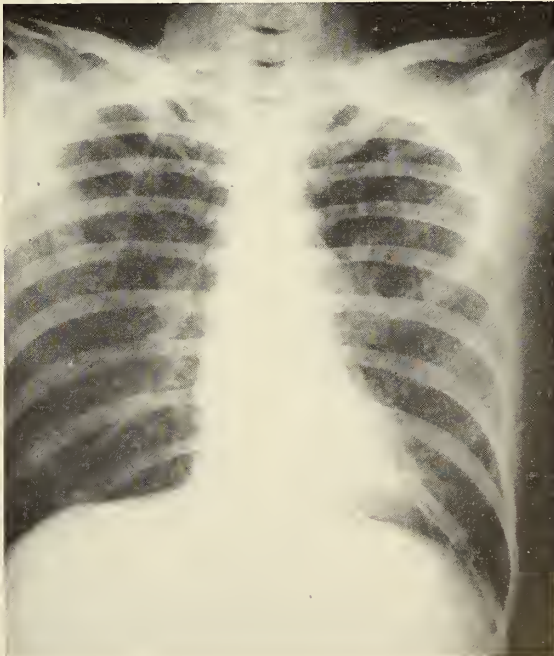
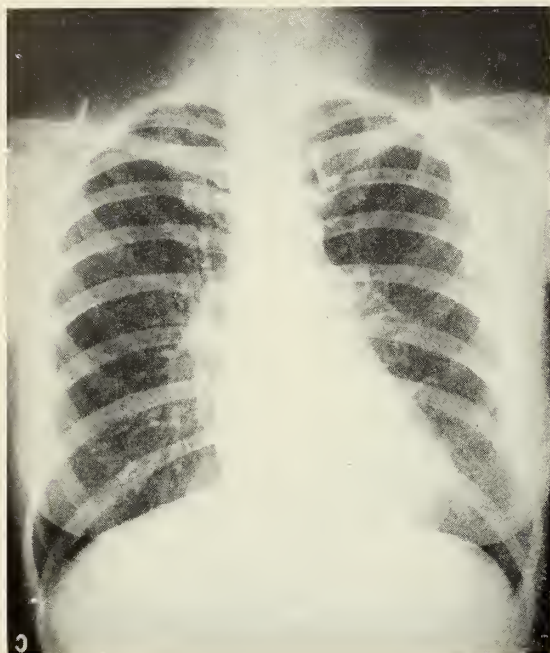


Figure 4



gram of the chest: "The pulmonary parenchyma on the right is clear. On the left, there is only faint thickening of the bronchial markings at the site formerly occupied by the pneumonic consolidation, and there is moderate exaggeration of the hilar markings on the left. Conclusion—largely resolved atypical pneumonia." (Figure 4.) She was last seen on September 6; she was asymptomatic and there were no chest findings.

DISCUSSION

Study of the case record impresses one with the insidious mode of onset. At first visit, this patient presented what appeared to be a comparatively innocuous case of tracheobronchitis. As the course of the disease progressed, and first penicillin and then sulfadiazine failed to bring about abatement of the symptoms, it was quite natural to believe that this case constituted a virus pneumonia as described by Reimann.⁹ It was the knowledge gained from the work of Heilman, Herrell and Nichols, Learner and Minnich, and others, plus two successfully treated, unreported cases in the senior author's experience, which led to the emphasis on the smear and culture, and the employment of streptomycin. In the two cases referred to, streptomycin brought about immediate cessation of signs and symptoms of Friedlander's pneumonia when penicillin and sulfadiazine had failed. It is to be hoped that physicians who read this report will refrain from administering streptomycin until confirmatory laboratory evidence of the presence of Friedlander's pneumonia has been obtained. Likewise, the toxicity of streptomycin must always be borne in mind. It is possible that this patient might

not have survived the period before streptomycin administration was begun if it had not been for penicillin and sulfadiazine. The meningitis cases reported by Jacob and Top⁸ seem to indicate that these drugs are of value in the treatment of Friedlander's bacillus infection. In any event, gram-positive cocci were never present in great numbers in the sputum, possibly due to the action of sulfonamides and penicillin.

CONCLUSIONS

1. A case of Friedlander's pneumonia with recovery under streptomycin therapy has been reported. It is not clear what role, if any, sulfadiazine and penicillin played in the favorable termination of this disease episode. It is possible that combined therapy with all three agents is necessary in refractory cases. It was our impression that streptomycin was by far the most effective of the three agents.
2. The common tendency to regard pneumonias not responding to penicillin and sulfonamides as being necessarily of virus origin probably accounts for the fact that some cases of Friedlander's pneumonia are overlooked.
3. It is recommended in all pneumonias not responding promptly to sulfonamides and penicillin, that sputum smears and cultures be obtained, with requests to bacteriologists to search for Friedlander's organism. Ideally, such smears and cultures would be obtained before any form of therapy is begun, but it is recognized that this is not always feasible.

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CHRONIC AND RECURRENT INFECTIOUS HEPATITIS; ITS RELATIONSHIP TO CIRRHOSIS OF THE LIVER†

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THE story of the clinical course of the disease of the liver now known as infectious hepatitis has probably not yet been told in its entirety. We are now accumulating information and data growing out of the widespread epidemics of this disease which occurred during the recent war to assist in completing our knowledge. The impact of this broad dissemination of hepatitis is also now reflected in a great increase in the occurrence of this malady in the general population. The usual concept of this disorder has been that it was an acute, self-limited disease with a rather low mortality rate. This view has been supported by the pathological investigations of Lucké in 1944.¹ This author studied the livers of fourteen individuals who had recovered from epidemic hepatitis and who died from accidents or unrelated diseases from one week to fourteen months afterwards. He found that the liver appeared normal grossly in all cases and that the lobular architecture was retained in every instance. Microscopic changes were present, varying according to the time elapsed since recovery. These changes were minimal and in nine of the fourteen cases the liver was completely normal. It was concluded that complete restoration of the liver occurs in nonfatal cases of acute hepatitis.

However, there have been indications for many years that the clinical course of this condition was sometimes unusually prolonged. Rolleston, for example, in his textbook of 1905 said, "Occasionally cases, which begin like ordinary catarrhal jaundice and eventually clear up, hang fire and last for months."² Eppinger, who must be credited with the recognition of the true pathology of the condition, then known as catarrhal jaundice, classified hepatitis in two groups: the hepatocellular, or common form, which was of relatively short duration, and the cholangitic form which he found to be more severe, of much longer duration and often difficult to distinguish from obstructive jaundice.

Watson in 1946 presented evidence both clinical and pathological which supports the view that certain cases of hepatitis are of a different type and that they pursue a course which may be markedly

prolonged and may terminate in a form of cirrhosis which he terms cholangiolitic cirrhosis.³

SYMPTOMATOLOGY

The acceptance of the concept of a chronic or recurring type of hepatitis has resulted in increasing reports concerning the clinical nature of this prolonged disease. It has been learned that these patients may present a variable picture. The complaints most commonly encountered have been persistent or recurrent right upper quadrant pain, discomfort or tenderness. This pain is rarely severe and may be described only as a sensation of heaviness or fullness. During the war many patients were observed who complained in this manner and because of lack of facilities for thorough investigation and because of the prevailing idea that the disease was invariably either fatal or resulted in complete recovery, many of these patients were erroneously diagnosed as malingerers or psychoneurotics. Anorexia is another common complaint. This may be associated with an intolerance for fats. This complaint was also commonly regarded as a psychoneurotic one and doubtless in many instances this was true, but prolonged observation in the postwar period led to acceptance of the intolerance to fats as a symptom in chronic hepatitis.

Enlargement of the liver is a very common finding in these patients and one of the most suggestive signs of chronic liver disease. Occasionally a patient is encountered in whom the diagnosis of chronic hepatitis may be satisfactorily established without having a palpable liver. The liver is very often tender and in cases in which it is not palpable there may be tenderness in the right upper quadrant of the abdomen. Jaundice at some time during the course of the illness is extremely common and, of course, highly suggestive of the correct diagnosis. However, at any particular time during the long course of these cases jaundice may be absent. This feature is demonstrated in some of the cases herein reviewed. Nausea with or without vomiting has been found frequently in this group of patients. Weakness and intolerance for exercise is another prominent symptom and one that has only been recognized in recent years. Recurrences have in some instances been attributable to overexertion. The need for prolonged rest in the treatment of

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patients with chronic hepatitis is emphasized by this experience. Intolerance for alcoholic beverages has been found in some of our patients with chronic hepatitis. Aggravation of abdominal pain, nausea, vomiting and other symptoms have been noted following ingestion of even relatively small amounts of alcohol.

CLINICAL LABORATORY FINDINGS

The laboratory criteria for the confirmation of the diagnosis of chronic hepatitis remain uncertain and disputed. The answer to a recent question in the "Queries and Minor Notes" section of *The Journal of the American Medical Association* lists the following tests as the most definite signs of persistent liver disease: elevation of indirect reacting serum bilirubin, retention of bromsulphthalein, increased thymol turbidity, increased values of serum globulins and increased erythrocyte sedimentation rate.⁴ The minimum abnormality of liver function tests necessary to establish the diagnosis of chronic hepatitis would be difficult to determine. There are some cases in which the clinical picture is strongly suggestive of chronic hepatitis in which little or no abnormality can be discovered by the usual laboratory tests. Cases are reported in which the laboratory tests have become entirely normal despite the persistence of a large, tender liver and other symptoms of hepatic disease. Case 3 of the present group demonstrates this point.

It is possible, despite the uncertainties, to enumerate the usual laboratory findings in these cases. Elevation of the serum bilirubin is, of course, accepted as confirmatory of the presence of hepatic disease. It cannot, however, be of use in differential diagnosis unless the test is performed serially over a long time. In cases of prolonged hepatitis the bilirubin will be found to vary greatly, rising and falling with exacerbations and remissions. The level may be quite high or very low, but the curve will usually be irregularly up and down. A positive cephalin flocculation test or thymol turbidity test is usually obtained in acute exacerbation of hepatitis. In some of the low grade chronic cases these tests were found to be normal. These tests have been found to remain positive in some chronic cases for many months, as in case 1. Retention of bromsulphthalein is very often abnormal in such patients. This test may remain abnormal for months after symptoms and other signs of liver disease have disappeared. Occasionally the test returns to normal in a patient who is thought to have persistent symptoms of hepatitis. Abnormalities of the serum proteins may occur. Usually depression of the albumin fraction is noted. In severe cases this may be a striking feature and will be found to reflect the severity of the process. In case 1 correlation between the degree of jaundice as shown by the bilirubin curve and the serum albumin is demonstrated.

Prolonged prothrombin time, elevation of serum alkaline phosphatase, increased urobilinogen excre-

tion and other laboratory evidences of liver impairment have been demonstrated in these cases, but with less regularity than the tests above mentioned. It must be confessed that the diagnosis of chronic hepatitis depends to a considerable degree upon confirmatory laboratory tests, but with full recognition of the vagaries and uncertainty of estimation of liver function by laboratory means it must be understood that no distinct pattern of liver function tests can be diagnostic, and that clinical signs and symptoms may be strongly suggestive of this disease in the absence of positive laboratory findings.

DIAGNOSIS

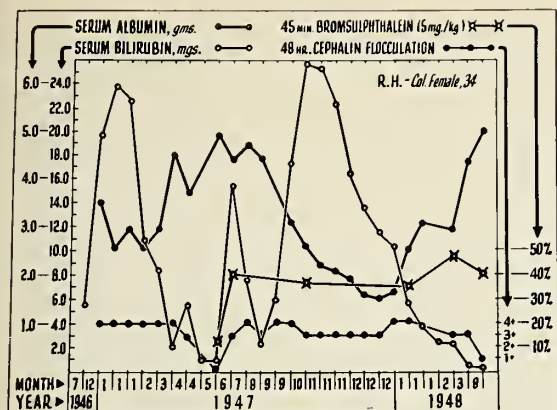
With increasing acquaintance with this type of hepatic disorder it is to be anticipated that clinicians will find that the diagnosis of chronic or recurrent hepatitis can be pretty well established on the basis of past history of an acute attack of hepatitis, plus symptoms and physical signs such as have been enumerated. This view is maintained despite the well-known observation that the liver function tests may be normal in patients who complain of many of the symptoms known to occur in hepatitis, as has been pointed out by Volwiler and Elliott.⁵ These authors also emphasize the fact that biopsy of the liver in many of these cases fails to show histologic evidence of persistent hepatitis or of significant scarring. It must be remembered that biopsies of the liver, particularly when obtained by means of a needle, supply a very small amount of tissue for examination and that even in cases where multiple biopsies have been made the possibility of missing a pathologic area in the liver is great. A recent case of carcinoma of the stomach with metastases to the liver demonstrated this source of error. A relatively large piece of liver tissue was removed at laparotomy and failed to show evidence of the malignancy which was found to involve the liver extensively at post-mortem.

HEPATITIS AND CIRRHOSIS

The possible relationship between chronic hepatitis and cirrhosis of the liver has aroused a great amount of interest and controversy. For many years the observation has been recorded that a rather high percentage of patients with cirrhosis of the liver gave histories of having had previous attacks of jaundice. From this evidence alone many writers in the past have assumed an etiologic relationship. In a review of one hundred six patients with cirrhosis of the liver seen at the Indianapolis General Hospital in the past ten years, 13.2 percent gave a history of having had previous attacks of jaundice. These observations cannot be regarded as constituting proof of causal relationship.

The material available for study in recent years, plus the increased use of liver biopsies by needle or at laparotomy, have provided a great deal of

Figure 1



Composite graph showing fluctuations in serum bilirubin, serum albumin, cephalin flocculation and bromsulphthalein retention in Case 1 over two year period of observation.

scientific evidence to indicate that posthepatitis scarring of the liver with the production of cirrhosis occurs. There is some disagreement as to the exact classification of this type of cirrhosis and even some evidence that it may vary from case to case. The nomenclature is therefore confusing. Watson, for example, reported histologic findings in a group of patients presenting cirrhotic changes superimposed upon prolonged hepatitis, in which he applied the term cholangiolitic cirrhosis, but which eventually may be indistinguishable anatomically from atrophic or portal cirrhosis. The difference between this group and the usual portal cirrhosis lies in the earlier stages, there being no intermediate hypertrophic fatty phase in the hepatitis cases. Others have described the posthepatitis scarring with nodular regeneration as "toxic cirrhosis." Still others regard this form of cirrhosis as a biliary cirrhosis of the type originally described by Hanot. Krarup and Roholm⁶ have described the pathological sequence of events as observed by needle biopsy studies. They observed the transition from the acute hepatitis with inflammatory infiltration with leukocytes, lymphocytes and plasma cells; followed by varying degrees of degeneration of the parenchyma and gradual appearance of streaks of fibroblasts, fibrocytes and collagen, with increasing connective tissue production extending from the periportal spaces. Eventually evidences of regeneration and hyperplasia are noted along with the inflammatory, degenerative and fibrotic changes. There is manifold evidence from the cases reported to date that all of the cases of cirrhosis following hepatitis must follow this pattern. Cases 1 and 2 of the present group are thought to demonstrate most of these changes.

Case 1. A colored female, age 34, was first seen in July, 1946, at which time she complained of jaundice, headache, nausea, anorexia, fatigue, epigastric distress and itching, all of which were about four weeks in duration. Her stools were very pale

and the urine dark. She was markedly jaundiced and the liver was enlarged to about 2 cm. below the costal margin.

She was known to have a positive blood serology which had been discovered in 1941. At that time it was diagnosed as latent syphilis. She received bismuth and arsenic over a period of two years. She had received no therapy for this since October, 1945.

The serum bilirubin on admission was 25.3 mg. She improved on diet and bed rest and was released, to be followed as an outpatient. In September, 1946, she received intensive penicillin therapy for her syphilis.

A severe recurrence of jaundice, associated with diarrhea and fever, began in November, 1946. The bilirubin rose to 19.7 mg. and the cephalin flocculation was found to be four plus. During this hospitalization a needle biopsy of the liver was done which showed a combination of acute inflammatory changes with degeneration of liver cells and marked fibrosis. She did not respond well to therapy consisting of a high protein, high carbohydrate, low fat diet, plus protein hydrolysates by mouth, brewers yeast and other vitamin supplements. The jaundice gradually subsided and the patient was able to leave the hospital in February, 1947. The bilirubin was 6.7 mg. but other liver function tests as shown in the table were not much improved.

Her bilirubin gradually diminished until it reached normal levels during May, 1947, and some improvement in her serum albumin and cephalin flocculation were noted. The liver had reduced considerably in size.

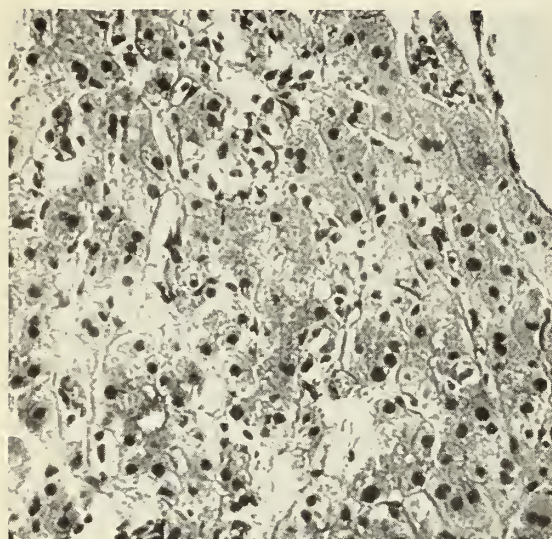
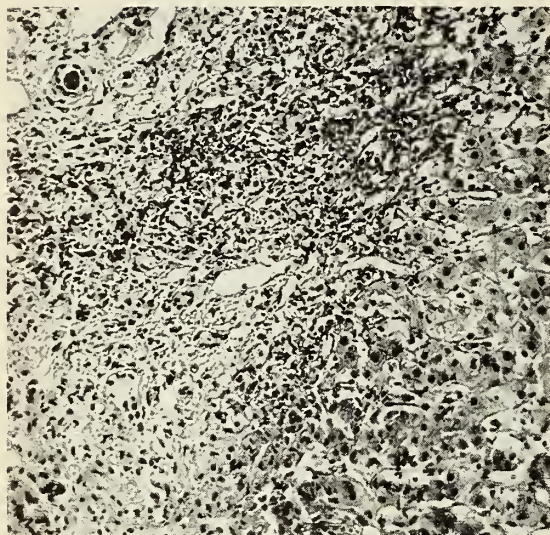
A sudden, severe recurrence developed in June, 1947, with dizziness, headache, jaundice and tenderness in the right upper quadrant. She was again hospitalized and placed on complete bed rest, and all dietary and medicinal therapy was intensified. The attack subsided within a month and the patient felt quite well. In September, 1947, another exacerbation occurred which was marked by extreme fatigue and serum bilirubin as high as 17.2 mg. Gradual improvement with reduction of degree of jaundice ensued during the next few weeks and by December, 1947, she was released from the hospital. Further improvement followed and during the spring of 1948 her bilirubin returned to normal and she felt very well. The patient's liver function was last studied in August, 1948, and the results are shown in the table. She still has marked dye retention and an abnormal thymol turbidity.

All x-ray examinations made on this patient have been normal, with the exception of the gallbladder, which failed to visualize on several occasions.

The course of the various liver function tests in this case are shown in the table. The bilirubin is seen to follow an unpredictable course with several periods of very severe jaundice. The serum albumin is seen to vary considerably and a reciprocal relationship between the albumin and the bilirubin levels can be seen. The cephalin flocculation test has shown a tendency to reversal. The thymol turbidity and the bromsulphthalein tests appear to remain unchanged.

This case is submitted as an instance of prolonged and recurrent hepatitis resulting in the development of a chronic process in the liver of a cirrhotic type. Lucké has pointed out the possibility that the scar tissue found in the livers of such patients as the one just described may have been present prior to the onset of the current hepatitis. There is no denying that this is a possibility, but the degree of fibrosis seen in such cases as this seems unlikely in a patient with no previous history suggestive of liver disease. The present patient was known to have had syphilis, but the pathology found in the liver is not characteristic of syphilis and this

Figure 2



Photomicrographs made from needle biopsy of the liver in Case 1, showing marked infiltration of inflammatory cells, degenerative changes in hepatic cells and increased fibrous tissue.

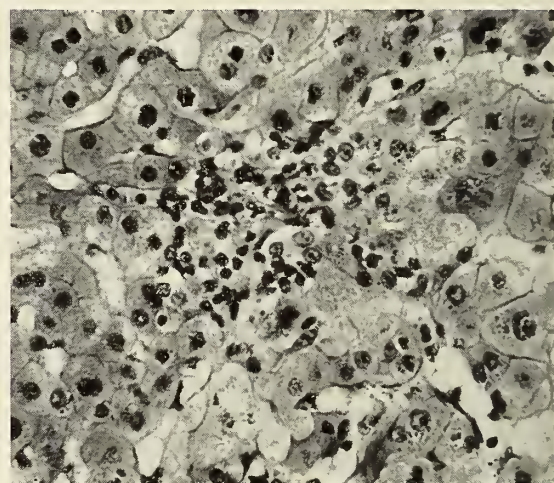
disease is an unlikely cause of the hepatic pathology found in this instance.

Case 2. A white male, age 62, was seen in September, 1945, with complaints of right upper quadrant pain, anorexia, weight loss and jaundice. He had a similar attack in June, 1945, at which time he ran a fever, but jaundice was not observed. The symptoms at the time of admission were of two weeks duration. He was found to be markedly jaundiced, underweight and tender in the right upper quadrant. The liver was not palpable.

There was a definite leukocytosis up to 14,000. The bilirubin was 3.3 mg. The cephalin flocculation was three plus at 24 and 48 hours. Sedimentation rate was 19 mm. per hour. Hippuric acid test, intravenous, showed 0.68 gm. excreted.

Gastrointestinal x-ray study was negative.

Figure 3



Biopsy taken at laparotomy in Case 2, showing infiltration of inflammatory cells, marked degenerative changes in liver cells and moderately increased fibrous tissue.

Treatment consisted of a high protein, high carbohydrate and low fat diet, vitamin B complex, vitamin K and amino acids. The patient did not seem to improve and exploratory laparotomy was advised.

At operation the liver was described as large, dark in color and smooth. The gallbladder was thickened but contained no stones. The gallbladder was removed and the common bile duct was drained.

In June of 1946, nine months later, the patient suffered another attack of right upper quadrant pain. This was followed by several milder attacks and the development of jaundice. On admission he was deeply jaundiced, his temperature was slightly elevated and the liver was felt two fingers breadth below the costal arch.

The white blood count was 21,000 on admission. The icterus index was 50, serum proteins were 6.7 gm. with albumin 3.2 gm. and globulin 3.5 gm.

Gastrointestinal x-rays were again negative and once more exploration was performed. The liver was found to be enlarged, soft, smooth and very dark in color. No evidence of extrabiliary obstruction was found.

A biopsy was taken from the liver which showed irregular fatty degeneration of the hepatic cells, much round cell infiltration in the portal triads and moderate fibrosis.

This patient has had no recurrence of hepatic symptoms since the summer of 1946; however, no laboratory investigation of his liver function has been made and it is problematical how much residual dysfunction persists.

Case 3. A white physician, aged 27 years, developed sudden right upper quadrant pain and enlargement of the liver in September, 1945. The symptoms subsided promptly on bed rest. In December, 1945, these symptoms recurred and in addition he complained of anorexia, food intolerance, and weight loss. A diagnosis of acute hepatitis was made and he was given a month's rest. He then entered the Army and passed a physical examination. He got along well until January, 1947, when he developed an acute pharyngitis, followed by pain and tenderness in the right upper quadrant and enlargement of the liver. Fat intolerance was again noted. At this time a cephalin flocculation test was normal. Following this attack he got along fairly well but observed occasional right upper quadrant distress, anorexia and fat intolerance. In April, 1948, these symptoms became more marked, he became very fatigued, itching and dark urine were observed, and he was then found to be jaundiced for the first time. The liver was enlarged to two fingers below the costal margin and was very tender. The icterus index was 23. There was 40 percent bromsulphthalein retention at 45 minutes. The sedimentation rate was 3 mm. Total serum protein was 7.5 gm., albumin 3.8 and globulin 3.7. Prothrombin time was 21 seconds and the control was 16 seconds. Cephalin flocculation was four plus at 48 hours.

The patient was hospitalized at this time and placed on a high protein diet with B complex capsules, vitamin C, methionine, choline and brewers yeast. He improved gradually with reduction of his icterus index and reduction of dye retention to 32 percent in 45 minutes and fall of the cephalin flocculation to three plus. In July, 1948, his icterus index was 8.7, the cephalin flocculation was one plus and bromsulphthalein test showed no dye retention. His serum proteins were 7.2 with A/G ration of 2.2:1. The patient continued to suffer from fatigue and exercise intolerance. His liver remained large and tender. He was continued on bed rest, plus dietary and vitamin therapy. He was discharged from the hospital in September, 1948, with advice to remain on a program of limited activities and dietary therapy.

Case 4. A white male, age 25, was admitted to the hospital in April, 1947, with complaints of jaundice, weakness, nausea and anorexia. He had jaundice and abdominal pain for the first time in 1945. This illness was diagnosed as acute hepatitis. The patient claimed to have suffered at frequent intervals from jaundice, headaches, anorexia, nausea and vomiting since the initial attack in 1945. The skin was moderately icteric on admission. The liver margin was not definitely felt, but it was thought to be enlarged. The icterus index was 65 and cephalin flocculation four plus on admission. The total proteins were 6.6 grams, albumin 3.9 gm. and globulin 2.7 gm. Gallbladder x-ray showed good visualization of the gallbladder without evidence of stones. The stomach and duodenum were normal. Treatment consisted of a high carbohydrate, high protein, high vitamin diet, with added vitamin concentrates and limited activities. The patient's jaundice subsided promptly and cephalin flocculation became negative. His appetite improved greatly and he gained weight. A bromsulphthalein test on June

10, 1947, showed no dye retained at 30 minutes. The patient was released with no evidence of active hepatitis after two months of hospitalization. This case was considered to be a recurrent hepatitis.

Case 5. A white male, age 29, first suffered from vague right upper quadrant pain in 1945. He does not recall any jaundice at that time. In September, 1947, he had a recurrence of right upper quadrant pain. Again in December, 1947, this pain returned and was then associated with jaundice, dark urine and light-colored stools. In August, 1948, he had a similar attack which lasted for one week and was associated with diarrhea. A gallbladder x-ray at that time showed no visualization of the gallbladder. It was not thought that the attack was due to gallstones. He was admitted to the hospital in October of this year, complaining of a heavy feeling in the right upper quadrant, diarrhea and marked fatigue. On physical examination he did not appear jaundiced. A few spider naevi were observed on the neck and anterior chest wall. There was tenderness in the right upper quadrant, but the liver was not palpable. Laboratory tests showed the blood count and urinalysis to be normal. The serum bilirubin was 0.4 mg. The total serum protein was 6.7 gm. and the albumin was 4.0 gm., and globulin 2.7 gm. The cholesterol was 210; cephalin flocculation and thymol turbidity tests were both negative. However, a 5 mg. bromsulphthalein test revealed that there was 22 percent retention at 30 minutes and at 45 minutes. The test showed 32 percent retention on a second occasion. The gastrointestinal x-ray examination was negative and cholecystogram showed nonvisualization.

The history, plus presence of spider naevi, when considered with a distinct retention of bromsulphthalein on two occasions, leads to a diagnosis of chronic hepatitis in this case with suspicion that cirrhotic changes are probably present in this man's liver.

Case 6. A white male, age 31, was admitted to the hospital in October, 1947. In July, 1947, he noticed heaviness in the epigastrium, anorexia and nausea. He also developed diarrhea at this time, with light-colored stools. His urine then became dark and he noticed icterus of the sclerae. He was hospitalized for three weeks and was much improved when discharged. Weakness and anorexia persisted and the patient was readmitted in October, 1947, because he developed itching, diarrhea and vomiting, as well as dark urine and light yellow stools. On physical examination he was found to be distinctly jaundiced and the liver was felt two fingers below the costal arch.

Laboratory tests showed the urine and blood count to be normal. Icterus index was 45. Cephalin flocculation was three plus at 24 hours and four plus at 48 hours.

The patient ran a low-grade fever during his hospital stay. He continued to complain of epigastric pain, nausea and anorexia. His jaundice increased for a time after admission. Treatment consisted of bed rest, high carbohydrate and protein diet, and vitamin supplements.

He began to improve about the first of December and gradually regained his appetite and strength. His icterus index was 7 on the fourth of December and cephalin flocculation two plus and three plus.

The patient was discharged with advice to remain at rest for at least another month. This case is considered to be one of unusually prolonged hepatitis, having lasted from July through December without interruption of symptoms. The man was clinically recovered at time of discharge, but no subsequent evaluation of his liver function is available.

DISCUSSION

There is little doubt that occasional cases of acute hepatitis pursue an unusually prolonged or recurrent course. Some cases appear to recover fully, only to suffer recurrent acute exacerbations. The symptoms in such patients are similar or identical to those of the familiar acute forms of the disease. Right upper quadrant pain and tenderness, jaundice, anorexia, nausea and vomiting, intolerance of fatty foods, weakness and hepatomegaly are the common symptoms. The exact evaluation of liver function tests in cases of chronic hepatitis is difficult. Most cases exhibit jaundice at some time during the illness. At times all symptoms may point to this disease and jaundice is not found; cases of this type have been presented. Bromsulphthalein retention is frequently abnormal in patients with chronic hepatitis and this may persist for many months. The cephalin flocculation and thymol turbidity tests have been positive in a high proportion of cases, but these tests are not uniform and cannot be depended upon for confirmation of the diagnosis. None of the remaining liver function tests which have been mentioned can be regarded as providing satisfactory and dependable results in all cases of chronic hepatitis. The clinical picture presented in the cases discussed show a high degree of uniformity and it is thought that the diagnosis of chronic or recurrent hepatitis can be strongly suspected on the basis of history and physical findings in most cases.

The possibility of a relationship between hepatitis and cirrhosis of the liver has long been suspected. Evidence is now obtainable through biopsy examinations of the liver during the course of hepatitis to indicate that inflammatory changes in the liver

may be followed by parenchymal degeneration and scarring. Numerous cases of this type have been reported in the recent literature. Two cases have been discussed in which the clinical diagnosis was chronic hepatitis and in which biopsies, one obtained by needle and the other at laparotomy, show inflammatory, degenerative and fibrotic changes. These case reports are thought to suggest that cirrhosis has developed on the basis of unusually prolonged and recurrent attacks of hepatitis. A large amount of material of this type must be studied and analyzed before it can be finally and irrefutably concluded that hepatitis may be an etiologic factor in the production of cirrhosis of the liver. Such an abundance of material is available in former military personnel and a long term investigation of these cases should ultimately provide the answer.

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DOCTORS CAN BE REACHED THROUGH TELEPHONE NUMBER LINCOLN 7323 DURING CONVENTION

Three telephone lines have been installed in Murat Temple for the convenience of physicians attending the Centennial Convention. The number is LIncoln 7323. It will be rotary service, which means the number will automatically produce a ring on any nonbusy line. A room in the Murat Theater lobby has been reserved as a telephone room, where doctors can receive and place calls. A member of the headquarters staff will be on duty to answer the phone, and medical school students will serve as pages.

SPONTANEOUS RETROPERITONEAL HEMORRHAGE SIMULATING APPENDICEAL ABSCESS

E. A. GARLAND, M.D.

EVANSVILLE

SPONTANEOUS retroperitoneal hemorrhage sufficiently great to cause surgical intervention for an acute abdominal catastrophe is not at all common. A rather comprehensive review of the literature on this subject reveals very few articles in reference to this condition.

Matheson reports in detail a case of retroperitoneal hemorrhage which occurred without any obvious cause and which was similar in many respects to the case herein reported.

It may be stated that the majority of the cases reported did not survive because of the tendency for the hematoma to become extensive in the easily separated layer of retroperitoneal areolar tissue.

CASE REPORT

Case: R. W., female child, age 2, was admitted to the hospital September 6, 1947. The patient had been in good health until forty-eight hours before admission, at which time her mother states that the child became sluggish and irritable but there was no complaint of pain in the abdomen at the onset. Appetite was very poor but no vomiting occurred. No history of trauma, except the usual childhood falls, was obtained. When examined just prior to the hospital admission, the patient appeared to be in acute pain. The skin was pale and drenched with perspiration. The temperature was 100 F, pulse was rapid and bounding.

The abdomen was moderately distended but there was no muscle rigidity. A large mass, approximately 3½ to 4 inches in diameter, was palpated in the right lower quadrant. Pressure on this mass caused considerable pain and induced vomiting. Rectal examination revealed a fluctuating mass in the right lower quadrant. The remainder of the physical examination was negative.

Complete blood count revealed: Hgb. 9.2 gm./100 ml., RBC. 3 million; WBC. 10,200; Band cells 10 per cent; Seg. N. 52 per cent; Lymphocytes 36 per cent; L. Monocytes 2 per cent. Urine specimen could not be obtained. Temperature at the time of admission was 102.6F. A diagnosis of appendiceal abscess was made and immediate operation was advised.

Under general anesthesia the abdomen was entered through a lower right rectus incision. Upon opening the peritoneal cavity, a large cystic mass was noted. The mass was covered with peritoneum and involved the entire right lower abdomen and a portion of the right lateral gutter forcing the

cecum terminal portion of the ilium and most of the ascending colon forward. The cystic fluctuating mass was bluish in color and no line of cleavage was noted between it and the colon. This cystic mass was opened on the lateral aspect to avoid the vessels of the mesocolon. Upon incision, approximately four to five hundred cc. of fresh blood, serum and clots were evacuated. There was evidence of early clot organization especially in the deep posterior portion of the cystic cavity. The clot was removed and the cavity was found not to communicate with any organ or structure in the abdomen. A rather dense clot was noted in the posterior wall of the cavity which appeared to be a clot in a fairly large vessel. This vessel was clamped and doubly ligated. Some seeping of blood was noted from the wall of the cavity. This was controlled by use of hot sponges. The appendix was found to be pushed forward and medially, along with the cecum. There appeared to be no acute inflammatory process present in this organ. The appendix was removed in the usual manner, the stump being left uninverted.

A stab wound was made in the abdominal wall lateral to the cecum and a medium sized Penrose drain was placed through the stab wound and into the cavity. Two pledgets of gelfoam were placed deep in the cavity and the original incision in the lateral peritoneum over the hematoma was closed. No pathology was noted in any other portion of the abdomen. The abdomen was then closed in the usual manner, using chromic No. 1 sutures.

Postoperative diagnosis was retroperitoneal hemorrhage with hematoma. Etiology unknown. The patient was returned to her room in good condition.

Subsequent treatment included parenteral penicillin and early ambulation. The drain was removed on the third postoperative day and the child made an uneventful recovery. Postoperative blood investigation included: bleeding time 30 seconds; coagulation time 3 minutes; sedimentation rate 41 mm/hr. (normal 0 to 20 mm.)

COMMENT

The preoperative symptom complex and laboratory data augmented by the physical findings would no doubt result in the diagnosis of appendiceal abscess in the minds of the majority of surgeons confronting this situation. Because of the apparent urgency of the case, immediate laparotomy was

advised. Needless to say, the origin of the hemorrhage must be found and proper steps taken to insure hemostasis.

A point of possible diagnostic differentiation in the preoperative diagnosis is mentioned by Matheson. In his report, he vividly describes the often observed picture of ruptured ectopic pregnancy in the female which is simulated to a marked degree in patients suffering from retroperitoneal hemorrhage.

CONCLUSION

A case of spontaneous retroperitoneal hemorrhage is reported because of its relatively infre-

quent occurrence and its possible confusion with other, more common intra-abdominal conditions.

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ECTOPIC PREGNANCY

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COLUMBUS

THE purpose of this paper is not to present any unique observation or new data on ectopic pregnancy, but rather to call attention to this acute abdominal condition that is often misdiagnosed. Ricco and DiPalma stated "in the diagnosis of ectopic gestation accuracy does not prevail."¹ This is attested by Miller² whose series had a correct diagnosis in only 47.2 percent of the cases. Litzenberg aptly stated "the most typical thing about an extra-uterine pregnancy is that it is atypical."³ Erwin VonGraff and Brown⁴ stated that in a well equipped and efficiently supervised institution as many as 307 ectopic pregnancies were surprises.

Therefore, if an accurate diagnosis is to be made in this atypical condition it is imperative that the surgeon and general practitioner be constantly on the alert, and that the symptoms and physical findings of extra-uterine pregnancy be thoroughly understood. Further, when a woman who is having sex life presents herself with an anomalous menstrual period, ectopic pregnancy must be excluded before any other condition can be considered.

INCIDENCE

There has been a wide variance in the reported incidence of ectopic pregnancy. Miller² estimates that one occurred in every 171 pregnancies; Newell¹ quoted one in 300 to 400 pregnancies; Woodhouse⁵ stated that ectopic pregnancy comprised 1.5 percent of the gynecological cases and 1 percent of the laparotomy cases in hospitals. DeLee⁶ found one in 600 cases of pregnancy. In Bartholomew County Hospital for the years 1941 to 1945, inclusive, there were 3,079 births. During this same period there were six ectopic pregnancies operated, one in 515 pregnancies. These figures are no doubt too high when one considers that many cases of

pregnancy terminated by abortion, with no record of the pregnancy being made. During this same period there were 88 abortions "cleaned up" in the Bartholomew County Hospital. Of course, there were many abortions, both criminal and accidental, which occurred during this time that terminated spontaneously and were not treated, recorded, or hospitalized.

ETIOLOGY

Anything that impedes the descent of the fertilized ovum to the uterine cavity is the cause of ectopic pregnancy. It immediately becomes obvious what the basic factors are that cause this condition; that is, disturbance in the cilia of the cells lining the tube, intrinsic or extrinsic blockage of the tube, and the ovum developing its capacity for implantation before it reaches the uterine cavity. Osiakina-Rojdestvenskaia⁷ add an additional factor, the motor capacity of the tube, which depends upon the effect of the vegetative nervous system. This nervous system may be influenced by various emotions such as fear of pregnancy, abortion, and use of contraceptive devices. Probably the most frequent cause of blockage of the tube is infection, and the most common pelvic infection is with the *Neisseria* organisms. No doubt the tubes are at times occluded from extragenital infection, such as appendicitis or diverticulitis. The tubes also might be obliterated or occluded from tumors and adhesions. Probably a fairly frequent cause of lack of patency of the tubes is abnormal embryonic development.⁸ Falk⁹ studied the proximal end of the involved tube in fifty cases at the Harlem Hospital. These tubes showed evidence of the end results of some form of low-grade infection in 95 percent of the cases. He found that mild salpingitis healed with pseudogland-like pockets capable of

catching the fertilized ovum. This type of follicular salpingitis not only followed gonorrhea infection, but also followed low-grade inflammation resulting from intrauterine contraceptives, uterine instrumentation or induced abortions. Langman and Goldblatt¹⁰ observed a high incidence of previous lower abdominal surgery in ectopic pregnancy. Mueller¹¹ adds the possibility of hormonal disturbance preventing the proper development and movement of the fertilized ovum.

PATHOLOGY

The changes that take place in the tube are comparable with those that occur in the uterus in case of pregnancy, except on a smaller scale, as would be expected in the limited space of the tube. There is a hyperemia of the tube with a swelling of the structures. The stroma cells enlarge and become decidual cells. The decidual cells are patchy and of no value as a nest in which the embryo may grow. The trophoblast cells of the ovum penetrate the tube wall and weaken it in the search for nourishment. This penetration, hemorrhage, and weakening of the wall finally result in a rupture of the tube in most instances. In other instances, the developing ovum is extruded from the tube and a tubal abortion occurs. The embryo dies at the time of the rupture or abortion.

SIGNS AND SYMPTOMS

As stated previously, the diagnosis of extra-uterine pregnancy is often missed. This statement is especially true in unruptured cases. Before rupture the signs and symptoms are those of early pregnancy, that is, amenorrhea, nausea and vomiting, and soreness of the breasts. Vaginal examination reveals a slightly softened cervix and perhaps enlargement of the uterus. Changes in size and consistency of the uterus are not usually readily ascertainable. Woodhouse⁵ states that the subjective symptoms of pregnancy, such as morning sickness and breast changes, are "conspicuous by their absence." Leon Miller¹² states that only one of 16 unruptured cases was correctly diagnosed in his series.

After rupture the symptoms and signs are more definite. These are amenorrhea of one month or more duration, followed by "spotting," or even by vaginal bleeding of a more frank nature. This bleeding occurs at a time not in rhythm with the regular menstrual cycle and the bleeding is usually dark brown or black in color. If the ovum dies the uterine decidua is cast off and this material may be obtained and examined. Davis¹³ found missed periods in 73.5 percent of a large group of cases. Urdan¹⁴ noted amenorrhea in 56.7 percent of his cases and abnormal bleeding in 81.4 percent.

Pain in the pelvis is another important symptom. It usually recurs in a fairly definite cycle. It may be sudden, severe, and lancinating, or resemble menstrual cramps. It often radiates to back, thighs,

shoulders and rectum. Pain is absent until there is hemorrhage. If a large vessel is ruptured the pain will be sudden and sharp and the patient will go into shock. The closer the pregnancy is to the fimbriated end of the tube, the more frequent the onset of pain is gradual. Falk⁹ states that 75.4 percent is confined to the lower abdomen and that 8 percent radiates to the shoulder. Syncope was present in 18.8 percent of this author's cases.

The degree of anemia present depends upon pathology and type of the ectopic pregnancy. The average hemoglobin is 60 to 70 percent.

Nausea and vomiting are frequently present and are probably due to peritoneal irritation. Falk⁹ observed it in almost one-half of the cases.

Physical examination reveals pelvic tenderness and enlargement of the uterus to a generous size. There is a boggy, usually nonsensitive, sausage-shaped or ill-defined mass in the region of the affected tube. Sometimes there is rigidity in the lower abdomen.

DIAGNOSIS

How far one can go afield in making an incorrect diagnosis in extra-uterine pregnancy is shown in the findings of Leon Miller.¹² In his cases the following misdiagnoses were made: pelvic inflammatory disease, forty-four; pelvic abscess, fourteen; uterine fibroid, thirteen; twisted ovarian cyst, eight; ovarian cyst, five; acute appendicitis, four; intestinal obstruction, three; pancreatitis, two. In considering differential diagnosis, the condition probably most difficult to differentiate is uterine abortion. In uterine abortion the bleeding is usually at a later date. The pain is more cramping in character and there is more bleeding than in tubal pregnancy.

Sometimes a ruptured mature follicle will cause bleeding into the peritoneal cavity, associated with pain, but in this condition there is no missed period.

As a rule the temperature is low in ectopic pregnancy. The blood in the peritoneal cavity does not cause a marked temperature reaction; however, the temperature may be high in old cases if infection is present. The pulse rate depends upon the amount of bleeding and shock present. Blood in serous cavities always causes leukocytosis and the polymorphonuclear count is high with hemorrhage. The blood pressure varies according to the degree of hemorrhage. The Aschheim-Zondek test is of no value except in a slow leaking tube with a viable ovum. A positive test is of great help but a negative test only means that the ovum is dead and that the trophoblast is no longer active. Cullen's sign is almost never observed.

Robert Miller¹⁵ recommends making several slides of curettings in doubtful cases. One may show decidual tissue and another may show placental tissue in the case of an abortion. Siddall and Jarvis¹⁶ state that their cases do not substantiate the claim that diagnostic curettage is dangerous,

and they add that there is no more danger of rupture of an ectopic pregnancy by this procedure than in doing a bimanual examination.

Although some authors advise against posterior colpotomy with a needle, Falk,⁹ Miller,¹² Torpin,¹⁷ and Fuller¹⁸ believe that it is a safe procedure and should be used whenever indicated to make a diagnosis. Fuller¹⁸ warns that a positive finding is of definite diagnostic value, but that a negative finding must be disregarded until other methods have proved that there is no bleeding in the peritoneal cavity.

Mueller¹¹ found that sedimentation tests were normal in twenty-four of his twenty-nine ectopic pregnancy cases. Curtis¹⁹ states the sedimentation test is of no value in differentiating tubal pregnancy from pelvic inflammatory disease.

TREATMENT

All cases of ectopic pregnancy are not operated upon, because many terminate spontaneously without ever being diagnosed. This should not encourage a procedure of "watchful waiting," however, because unless the patient is operated upon, almost all ectopic pregnancies will die. Miller² gives statistics collected by Parry of 500 ectopic pregnancies with 386 deaths; 174, or 52.8 percent, resulted from hemorrhage.

There is complete agreement among all authors of the necessity of operation in every case of ectopic pregnancy, but there is a diversity of opinion as to the exact time and amount of preparation necessary in these cases. One school believes that operation should be performed immediately after diagnosis is made.¹¹ This view is held by well-known men, such as Schuman, Just and Watkins. Falk⁹ believes that no transfusion or infusion should be given until the hemorrhage is controlled. Miller² believes the dictum that all cases of ectopic pregnancy should be subjected to operation as soon as possible, regardless of the patient's condition, and that this should be the unvarying rule of every physician. Schaufli²⁰ believes that the blood of the donors, if limited, should be conserved until the vessel is ligated.

The other school, supported by the late John O. Polak, believes in delaying operation until the hemorrhage is partly controlled by clotting and the patient has been allowed to react, which he states always occurs, and until the blood pressure, which may have been imperceptible, has become elevated to a systolic of ninety or above. In the meantime, he combats shock with heat, Trendelenberg position and morphine. He believes that a transfusion should not be given until the bleeding point has been controlled. Others, such as Waters,²¹ are of this same opinion; that is, no surgery should be undertaken until recovery from shock and hemorrhage has taken place. He differs from Polak, since he gives supportive treatment with transfusion and fluids while waiting for the patient to react.

I am of the opinion that a course between the two schools is probably the best procedure to follow; that is, immediate operation combined with shock treatment with morphine and Trendelenberg position, if necessary. It is probably best to not give fluids or transfusion until the operation is started or the bleeding point is ligated, except in the desperate cases that seem to be getting worse before arrangements can be made to operate. It seems illogical to let a patient die without operation because one adheres strictly to the school that the patient will respond, which does not take place or perhaps took place before the patient came under observation.

As to the technique of the operation, all are agreed that the first necessity is to control the bleeding. This can be done by placing a clamp on the infundibulopelvic ligament and another clamp near the cornu of the uterus, after which the tube and the ectopic pregnancy are excised.

According to Newell,¹ Johannes Thies of Leipzig is accredited with being the first to utilize free intra-abdominal blood for infusion in 1914. Alice Y. Y. Chang²² recommends removing the blood with sponges, filtering, and then citrating it with a 2 percent solution. Newell¹ gives the following contraindications to autotransfusion: malignancy, infection, and old, stagnant blood from long-standing cases. Shaw²³ used autotransfusion in over one-third of his 122 cases. Chang²² lists the following advantages of autotransfusion: saves time; no danger of cross-infection; most economical; reactions are less severe.

I have never had occasion to use autotransfusion, but if the necessity arises, a simple method would be to aspirate the blood into a transfusion bottle that contains citrate solution. This could then be given as an ordinary transfusion.

The decision as to disposition of the other tube depends upon its condition and the number of children that the patient has. Mayo and Strassman²⁴ state the probability of intra-uterine pregnancy after ectopic pregnancy is ten times greater than the likelihood of another ectopic pregnancy. He therefore advocates conservative surgery in order to preserve fertility and advises removal of the other tube only when it is severely diseased. MacFarlane²⁵ says that recurrence occurs in an average of around 3.6 percent. There was a recurrence of 10 percent in his series. Even though the chance of a normal pregnancy is much greater, a recurrence of 3.6 percent is great enough that I consider it advisable to remove the other tube, even though it is not apparent grossly that it is diseased, if the mother has living children.

The mortality rates as given by various surgeons vary from 2.2 percent of operated ectopic pregnancy cases to 10 percent. Most of the authors report a rate of around 2½ to 3 percent. Falk and Rosenbloom²⁶ had a mortality of 8.3 percent in their cases.

CASE HISTORIES

Two case summaries are presented to illustrate the common course of events in ectopic pregnancy.

Case 1. E. P. This patient, a thirty-three year old, white woman, was admitted to the hospital because of pain in the lower part of her abdomen. She stated that the pain started about a week before her present admission. The pain became more severe about a half hour before admission. She gave no history of faintness or nausea and vomiting. Menstrual history was regular and of about a twenty-eight-day cycle, until her period in February, which was ten days early. In March her period was at the normal time but it only lasted one day and was not as heavy as usual. Her marital history is of interest, in that she had been married nine years and had had no pregnancies, although no contraceptives were used. She had had no previous operations or history of pelvic inflammation. There was no nausea or vomiting. The physical examination was negative except for the following findings. There was tenderness in the lower part of her abdomen, with distant bowel sounds and rather marked abdominal distention. Bimanual examination revealed no definite masses. The cervix was not soft or patulous, and the uterus was palpated with some difficulty and did not seem enlarged. The blood pressure was 120/60. The laboratory findings were: normal urine; R.B.C. of 3,290,000; 8 grams hemoglobin; W.B.C. 19,900; clotting time 3' 50"; bleeding time 1'; differential: 87 percent polymorphonuclears; lymphocytes, 12; stabs 17, segs 70, monos 1. A blood count about two hours later revealed essentially the same count.

At operation bluish discoloration of blood was seen through the peritoneum before it was opened. An ectopic pregnancy was present in the ampullary region of the left tube and bleeding was fairly active. A few adhesions were present around the left tube. Two small fibroids were present in the uterus and the largest one was removed after the involved tube was excised. The appendix was also removed. The blood removed from the cul-de-sac showed some signs of organization. Five hundred cc. of citrated blood was given after the operation. The patient's postoperative course was uneventful.

Case 2. H. W. This patient, a white female, aged twenty-six, entered the hospital complaining of pain in her right side, nausea and vomiting, and also pain into her right sacro-iliac region. The attack started about eight hours before her hospital admission, with pain in her right side, nausea and vomiting. The pain in the right sacro-iliac region was present at the beginning of the attack. The pain was constant and severe. Six days preceding this attack she had a similar one that lasted for half a day. The same symptoms were present at this time. She stated that she was perfectly well between attacks. Her last period was May 21, before the admission date of July 18. She had three children born by normal deliveries and had a miscarriage of four months gestation five years ago. The following physical findings were significant. Blood pressure was 120/80. There was tenderness over most of the abdomen and this tenderness was most marked low in the region of the bladder, and above Poupart's ligament on the right side. The uterus seemed enlarged and a questionable mass was felt in the right adnexal region. Examination was not too satisfactory because of the discomfort caused the patient during the examination. Laboratory examination revealed a normal urine. The W.B.C. was 12,700; clotting time 3' 15"; differential: polys 75, lymphs 19, bas 2, eosins 2, Juveniles 1, stabs 6.

At operation a right rectus incision was made. Blood was observed in the peritoneal cavity before

peritoneum was opened. The right ruptured tubal pregnancy was removed in the usual manner. The pregnancy occupied about the mid-portion of the tube. The appendix was also removed.

DISCUSSION

Both of these cases present some interesting points. Both cases gave a history of prolonged pain or a recent attack within a short period. The pain in both cases was the result of prolonged slow bleeding or intermittent bleeding of the ruptured tube, which is often the case in ectopic pregnancies. In both cases the blood pressure was normal because the hemorrhage was neither massive nor sudden. Further proof of previous bleeding was shown in case 1 by the partly organized blood observed in the cul-de-sac. One case had menstrual disturbance but no period of amenorrhea. This case had no amenorrhea but instead had a period ten days early in February, followed by an abnormal period in March of one day. It is probable that both the bleeding in February and in March did not represent a menstrual flow but instead, vaginal bleeding, associated with the ectopic pregnancy. This has been discussed earlier in this paper. The second case had an amenorrhea of around four weeks duration. One case had nausea and vomiting, the other had none. The physical findings in both cases demonstrate that reliance can be placed on no one symptom or finding. In the first case the uterus and cervix seemed normal and exhibited no signs of pregnancy. No mass was felt in either adnexal region. In the second case the uterus was enlarged and a mass was felt in the right adnexal region. Tenderness was present in both. In both cases the W.B.C. was increased but no greater than might be found in an acute appendicitis or acute pelvic inflammatory disease.

In each case there was a symptom or finding that is not usually associated with an acute appendix. In the first case it was the marked abdominal distention with a practically silent abdomen. This finding is often present in ectopic pregnancies and is due to peritoneal irritation from blood in the peritoneal cavity. In the second case it was the referred pain that the patient complained of in the right sacro-iliac region. In both cases there were enough findings or symptoms to make one suspicious of an ectopic pregnancy, but in both cases the picture was not complete. These two cases demonstrate the necessity for constant vigilance so as not to miss this serious acute abdominal condition.

CONCLUSION

One should always consider an ectopic pregnancy in a woman of child-bearing age with an acute abdomen. To make the diagnosis it is imperative that physicians and surgeons thoroughly understand the symptoms and physical findings of extra-uterine pregnancy. The only safe treatment for this serious condition is early operation. Through

early diagnosis and operation the mortality in this condition should continue to decrease.

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QUESTIONS WANTED FOR PANEL DISCUSSIONS

Physicians are invited to submit questions on the subjects of "Peripheral Vascular Diseases" and "Hospital Rules and Regulations," which will be discussed by panels on Wednesday afternoon, September 28, and Thursday afternoon, September 29, respectively, during the annual session.

The questions on "Peripheral Vascular Diseases" should be mailed to Dr. Ralph U. Leser, chairman of the Committee on Scientific Work, 207 Hume Mansur Building, Indianapolis 4. Questions on "Hospital Rules and Regulations" should be sent to Dr. John D. Van Nuys at the medical center. The questions will then be turned over to the moderators. Receipt of the questions prior to the meeting will enable the panel leaders to present a more interesting program.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

NATIONAL EDUCATION CAMPAIGN

THE REPORT made recently by Whitaker and Baxter to the House of Delegates of the American Medical Association on the progress of the AMA National Education Campaign, besides being a factual report, is also a testimonial to the zeal and earnestness with which these two campaigners have entered the fight against compulsory health insurance.

In recognizing that the present move toward politically-controlled medicine is but a part of the world-wide trend toward socialism, they have placed the campaign on a high moral plane. Miss Baxter stated that "We have to restore the economic and political health of the country. We have to renew faith in the sound precepts that we know will keep America healthy and strong, and, from the standpoint of the Nation's health, protect it from those who would sacrifice it to politics."

The campaign was originally announced as one which would extend over a considerable period of time, since it would not be concerned merely with the defeat of proposed legislation, but would be primarily aimed at correcting the conditions which helped to foster the socialistic trend.

In this connection Miss Baxter announced that "We urgently need to present the principle of voluntary health insurance to the American people. We need to encourage the American people to provide themselves with prepaid medical care and to give them the facts in order to prove to them there is nothing government can do for them in this field that they can't do better for themselves, and at less cost."

About 25 different types of informative material have been prepared, and 25,000,000 copies were

distributed prior to the AMA meeting. These pamphlets, booklets and folders are varied as to size and form, and present the facts about medical care in a variety of ways. Now that they are available and have been distributed to medical societies and to individual physicians, the problem is to insure their further distribution to the people.

Whitaker and Baxter have found that there is a tremendous public interest in the question of medical care, and that the people are anxious to receive information regarding it.

At the present time it appears that Congress may not be able to act on compulsory health insurance legislation during the present session, and that the attack may be shifted to the 1950 Congressional elections. This is indeed fortunate, since it will place the decision squarely upon the people who will be affected most if government medicine is adopted. It will mean that the public will require more and more information. It makes the distribution of our informative pamphlets more and more important.

One of the most heartening things in the campaign is the number of national organizations which have aligned themselves at the side of medicine. The American Farm Bureau Federation, the American Legion, the American Bar Association, the National Grange, the National Association of Small Business Men, the National Fraternal Congress, and the General Federation of Women's Clubs are a few of the large organizations concerned. Nearly 800 organizations in all have announced themselves as opposed to compulsory health insurance.

It is not necessary that all such sympathetic organizations be national in scope. In fact, the National Education Campaign as outlined in the beginning recognized that endorsements and resolutions would be sought from state and local organizations as well as on a national level.

Now that the fall session of Congress will soon be convened, it is important that the state and county medical societies renew their campaigns to enlist the support of lay organizations. Also, we must not forget that every medical society should have a resolution condemning compulsory health insurance in the hands of the President and our congressional representatives at an early date.

Now is the time for all coordinating committees to encourage the support of civic groups, lodges, churches, farm bureaus, parent-teacher associations, chambers of commerce, labor unions, clubs and patriotic organizations. Indiana has done well in the endorsement drive and has contributed its fair share of the work. We have made a good start, and now that the national campaign is gaining a powerful momentum, we must make sure that every public organization in Indiana is given the opportunity of expressing its opposition to political medicine.

HOW CANCER FUNDS ARE BEING USED

WE OFTEN hear the statement that this or that agency "has more money than it knows what to do with."

The size of the money pile is a relative thing. One needs to know the size of the job to be done and what is being done before passing judgment on resources. Interest or lack of interest in a subject also makes a tremendous difference in evaluation.

The Indiana Cancer Society will receive from public donations this year about \$300,000, possibly less due to economic conditions. Of this amount 40 per cent, or \$120,000, will be sent to the national organization in support of its country-wide program of research, and professional and lay education. Another 40 per cent remains or is returnable to the 92 counties in proportion to the amounts they raise. These funds provide the services selected by the medical societies in those communities. This leaves 20 per cent, or \$60,000, for use on a state-wide basis, controlled by the Executive Committee and Board of Directors of the Indiana Cancer Society, which is a legal, non-profit corporation.

No lay health agency has so many medical men on its boards and committees as does the Cancer Society, and its constitution and bylaws make major activities or expenditures subservient to the wishes of organized medicine. Dr. Chester A. Stayton, Chairman of the Indiana State Medical Association Cancer Committee, is Chairman of the Executive Committee and is a Vice-President heading the Research Committee. Dr. Thurman B. Rice is Director of Lay Education, and Dr. Don D. Bowers serves as Director of Professional Education. The Executive Director, Rollis S. Weesner, was formerly Executive Secretary for the Lake County Medical Society and is widely known and highly regarded by the physicians of Indiana. The President of the Society is William H. Ball, Muncie manufacturer, who is well known for his record of unselfish service and philanthropy and interest in medical subjects.

In reviewing the program of the State Cancer Society, which includes eleven projects, some expensive and of major importance, which have present value to our work as medical practitioners, we cannot help but conclude that the money is being spent wisely and many benefits are being made possible if we only take advantage of them.

The symposia sponsored through the Medical School have been truly outstanding and attendance should increase greatly for these short courses in the future. Manuals, brochures and other literature supplied to all doctors are excellent and Dr. Bowers now announces scientific films, slides, statistics and other aids for use in staff and medical society meetings.

Research is being carried on by Indiana University, both of Indianapolis and on the Bloomington campus, and by Purdue University, as well as in hospitals and laboratories. We cannot go into detail here relative to the extent or purpose of this research, which in every case adds to professional knowledge, and might well be termed education as well as research. These projects include cytological investigations, and study of genetics, virus growths, reactions of carcinogenic substances to certain drugs and the amino acids. The gathering of statistics, the teaching of new laboratory techniques and the development of a state-wide cancer registry are supported at the state level. The Society also supports fellowships in pathology at the Medical School, aids the School of Public Health and the State Board of Health in cancer education, and supplies radon for indigents at the Medical Center.

Adding this program up in terms of money, the budget last year, including money returned from the national society, and the Elks and Lions Clubs, amounted to \$110,000. Of this amount the Indiana Society supplies \$37,144.50, which would leave approximately \$23,000 of the state's 20 per cent for lay education, campaign and administration, or about 7½ per cent of the total money raised.

Considering the state-wide nature of the Cancer Society, involving the supervision and promotion of county programs and campaigns, as well as implementation of the state office program, we would say they were doing very well.

"CONTRASTS IN METHODS"

(Editorial Reprinted from *Chicago Journal of Commerce*, June 2, 1949).

THE American Medical Association has done an unusual thing!

In order to combat misrepresentation of the purposes and methods of its publicity campaign against compulsory federal health insurance, AMA has sent to every member of the 81st Congress a complete, booklet-form breakdown of the association's plan of action.

Prepared by Whitaker & Baxter, the public relations firm which is directing the AMA's drive, the booklet carefully blueprints every step to be taken at the county, state and national level.

If members of Congress take the time to read

the plan, AMA's professional and lay critics will be wasting their time when they charge the organized doctors with sly, unethical propaganda.

Compare this candid, open position with the statements of Acting Security Administrator J. D. Kingsley when that gentleman testified recently before a Senate committee.

Mr. Kingsley testified that Mr. Truman's compulsory health insurance program would cost \$5,-600,000,000.

If the administration were half as frank as the AMA directors, it would instruct all its witnesses to tell Congress that all cost estimates are at best only informed guesses—and not too well informed at that.

No similar system anywhere ever has remained for more than a year at most within the original estimate. The cumulative costs of such schemes cannot be estimated.

Mr. Kingsley also played a variation of the President's theme that existing voluntary health insurance plans "have proved inadequate." These plans, said the acting security administrator, cover only some 32,000,000 people "with limited hospital care only." His general conclusion was that voluntary health insurance costs too much for most people and cannot pay its way on lower premiums.

That statement of the case is considerably less than frank. What Mr. Kingsley did not tell Congress, for example, was that the Blue Cross insurance plan was not established until 1934. During 15 years it has had the phenomenal growth of more than 2,000,000 members a year.

Nor is it true that private plans provide for hospital care only. We now have Blue Shield which insures its members on actual medical service provided by doctors and surgeons. Blue Shield, which has had a somewhat slower acceptance than Blue Cross (largely for the reason that hospital care is usually a much heavier burden of illness than the doctor's bill) nevertheless now has some 10,000,000 members and is growing daily.

The AMA proposes to sell the American people on the idea that voluntary health insurance is preferable in every way to a compulsory scheme administered by government through state and local officials.

The federal government, which ought to be encouraging Americans to provide for their own care from their own incomes, instead belittles private insurance plans by telling Congress that such programs are inadequate.

Actually, in this controversy, the American Medical Association seeks to preserve the traditional American way as opposed to a federal administration trying its best to destroy that way.

If the nation's press intends to give any prizes for honesty of purpose in this battle of words, let them go to the AMA.

MILITARY MEDICAL SERVICE

SECRETARY of Defense Louis Johnson has addressed an appeal to young American doctors in full-page statements which are appearing in medical journals. Because the armed services have felt honor bound to release physicians who have been serving temporarily, and who during this year have completed their normal tour of service, a serious shortage is developing in the medical departments.

It is traditional in the United States that the medical requirements of the Army and Navy, and more recently those of the Air Force, in times of emergency always have been supplemented by the voluntary services of civilian doctors. It is a matter of no little pride that individuals of the American medical profession have, on many occasions sacrificed their own comfort and personal interests, either by entering the services, or by assuming added burdens at home.

During World War II doctors of all ages, by the tens of thousands, were so engaged in the Army and Navy, and their confreres on the home front performed the gigantic task of caring for civilian needs with greatly decreased numbers. Since the war the retention in the service of the younger medical officers, on a temporary basis, has made possible a high quality of medical service.

The present situation does not involve a decrease of the number of doctors available for the civilian population. All that is needed is replacement of the physicians who have fulfilled their duty-obligations, and who are now about to return to civilian practice.

There is at present a sufficiently large body of young doctors who were educated at government expense, or who were excused from military service during the war in order to complete their education, and who have seen no active service, to fill adequately the present military needs.

It is to these men that the Military Establishment and the medical profession are looking. The government does not have any legal hold on this group, despite their scholarships and deferments. This is as it should be. The medical care of the armed services always has been accomplished on a volunteer basis, and there is no reason why it cannot be so accomplished in 1949.

Peacetime military medical service has much to commend it as a means of postgraduate professional training. This has been particularly true since the war. As a result of war experience all the Armed Forces have realized the advantages of continuing clinical study and have instituted training programs which rival those of the best civilian postgraduate centers. The opportunities for general and specialty training, together with housing preferment which is afforded medical officers, the \$100.00 per month bonus which is paid all vol-

unteer medical officers, and the opportunity to fulfill obligations incurred during their medical education should make a favorable impression on all doctors who are contemplating a training period in the armed services.

OUR GREAT OPPORTUNITY

WITH typical generosity Eli Lilly & Co. has subscribed \$50,000 to help pay the equipment costs of a new research wing at the James Whitcomb Riley Memorial Hospital. This open hearted gift will add new impetus to the already effective campaign of the Riley Memorial Association to raise \$1,000,000 to support a continuing research center at the children's hospital.

By the 100th anniversary of the great Indiana poet's birth, the association hopes to have the \$1,000,000 it requires so that the new center can be started. The need for expanded research in children's diseases is obvious to anyone who has ever visited Riley Hospital and seen the hundreds of maimed and crippled youngsters who are being so well cared for there. Indiana has a great opportunity this year to make possible the most outstanding research center of its kind in America at the hospital; to attract the very finest scientists and medical researchers from all parts of the world who can work together to find the causes and the cures of those terrible diseases that cripple and handicap innocent children.

There has been some premature talk of combining all charity fund drives into a single united campaign sometime in the future here in Marion County. But so far it is mostly talk. The Riley campaign is a fact, long prepared and ably conducted. The people of Indiana should not let the disclosure of indefinite plans of community leaders cause a letup in the drive to raise the much needed \$1,000,000 this year. The lives and good health of thousands of little children depend on it.

The Indianapolis Star, June 2, 1949.

The response to the printing of the schedule of the Instructional Courses in the August, 1949, issue of THE JOURNAL has been active. At the time the September issue is going to press no class is closed, but a number of them have reservations indicating that the full selection of classes will not be available long beyond the issue of the September JOURNAL. Members who plan to attend this course are urged to make reservations promptly.

President's Page

TO THE HOUSE OF DELEGATES

THE Indiana State Medical Association stands on the threshold of a new century in Indiana medicine. A grave and important responsibility rests on your shoulders, for you are the legislative and business body of the association. Your official transactions largely determine the policies and future progress of scientific medicine in Indiana.

Individually you have been honored and entrusted to represent and speak on behalf of your county medical society.

I feel that it is my duty to inform you that you will face a tremendous job in this centennial year. Our state committees have been exceptionally active during the year and have much to submit for your consideration. Our county medical societies are alerted as never before and will send their delegates with many specific recommendations. Most of the physicians of Indiana realize that there is a crisis in American medicine that must no longer be postponed. They want something done about it and they look to you to do the job.

For this reason I respectfully request you to read and study the many committee reports printed in this issue of THE JOURNAL and in the official Handbook, review the transactions and the recommendations of the Executive Committee and the Council for 1949, and determine the wishes of your county medical society before you come to the meetings of the House of Delegates.

I respect the House as a great and sincere deliberative body and I am confident that your decisions in this critical and important centennial year will be unselfish and unprejudiced, in the best interest of the medical profession and the health and welfare of humanity.

TO THE CENTENNIAL PROGRAM COMMITTEES

For more than a year our great centennial has been in the making. You busy physicians, your wives and daughters, ably assisted by a most efficient headquarters staff, have given unstintingly of your time in arduous preparation for this historical and epoch-making event.

THE STAGE IS SET, a great cast has been assembled, and soon after this page comes off the press the curtain will go up and the show will go on—four straight days and nights of brilliant pageantry depicting one hundred years of progress of scientific medicine in Indiana. We will be thrilled and we will enthusiastically applaud the greatness of it all.

WE WILL NOT FORGET that behind the scenes of this honorable and glorious tribute to the one hundredth birthday of our association there are men at work, and ladies too, the members of the many committees, and the headquarters staff, who are putting on the show. Space will not permit the individual praise each deserves and they will have little time to take a bow before the curtain falls, so

THANKS A MILLION AND ORCHIDS TO YOU ALL.
YOU DESERVE YOUR FLOWERS NOW.

Augustus D. Hauss

Medical Panorama *by the* ASSOCIATE EDITOR

CAVEAT EMPTOR

The inevitable tendency for bureaucracy to expand has been the theme of many an essay and the sad observation of many a citizen. *The St. Louis County Medical Society Bulletin* gives some facts and figures quoted from William Bromme in *Detroit Medical News*:

"Several weeks ago we commented on a newspaper report that there had been collected \$13,394,000,000 in payroll taxes for old age benefits and that there was a credit in the Federal Treasury of \$10,706,000,000 for this fund. Payments to pensioners had totaled \$2,379,000,000 at an administrative cost of 13 per cent of the disbursements."

A little arithmetic shows that the money which the pensioners did *not* get but which was eaten up by administration costs (in other words, by bureaucracy) was \$309,000,000, a tidy sum. But that ain't all, mister. Our Detroit colleague goes on to say:

"Let me quote the newspapers of March 26, 1949. 'Arthur J. Altmeyer, social security administrator said that there is a \$7,000,000,000 "deficit" in the social security old age and survivors insurance fund. It is not a current cash imbalance, he explained, but a lack of provisions for future obligations created by promised benefits. But Altmeyer told the House Ways and Means Committee that if Congress now raises the payroll tax to 3 per cent against employer and employee this will wipe out the deficit and provide for increased benefits under the new program proposed by President Truman.'

"The little group of social planners in Washington have a glib way of juggling the words deficit, cash imbalance, credit, lack of provision and it is small wonder that Mr. Average Citizen is developing a deep suspicion that the only place where real money enters the picture is the progressive deduction from his pay envelope—and that from this point on, billions can become imbalances, deficits, credits, lack of provisions without ever entering the realm of money again. He has good reason to ask that further attempts to increase his payroll 'contribution' for other federal services be moved from the sphere of philosophy to the field of honest cost accounting.

"For Mr. Average Citizen has a right to certain things, one of which is integrity in those who plan his life for him. And it cannot be said, in the face of this sorry demonstration of the ineptness of the planners of the social security system, that he has any reason to expect that he will receive any improvement in his health from another payroll deduction. For won't this, in a decade, become another matter of deficits, cash imbalances, credits, lack of provision of sufficient degree to require another payroll deduction?"

With such things going on and further encroachments in the offing, how can any Hoosier M.D. forget, or fail, to send in his assessment to the A.M.A.? United, we stand, divided, we'll crawl.

FOR EARLIER TREATMENT OF CANCER

The *Westchester Medical Bulletin* for June 1949 contained a well considered article by A. J. Conte, M.D., of Memorial Hospital, New York, on "Delay in the Treatment of Cancer." After a detailed factual analysis of his subject, Dr. Conte makes the following practical statements:

"One cannot conduct a continuous campaign for the laity at the tempo of the annual cancer month sponsored by the American Cancer Society. There are too many competitors for the public's attention, so that the words cancer—delay—early treatment—are difficult to strike home. The obvious solution of this problem is for every physician to conduct an educational campaign with each one of his patients throughout the year. This must be accomplished by deed as well as by word. By deed is meant an annual complete physical examination of all patients over 40 years . . . it should include a blood count, a urinalysis with careful microscopy, a fluoroscopic examination or roentgenogram of the chest and a protoscopic examination for very obvious reasons. While it may not represent such a great work load, it does mean that a great many physicians would have to change their work habits. It is not expected that every physician will become a specialist in cancer diagnosis but, by such a process, he should be able to separate the obviously normal people from those who are suspects. If he is not prepared to complete the diagnosis himself, he should then refer these patients to an appropriate physician — or clinic for further study to determine whether his suspicions are well founded. The initial screening process must be carried out by the individual physician. A careful annual examination as outlined would detect a great many early cancers and if these were dealt with promptly and properly the morbidity and mortality of cancer would show a precipitous drop almost at once. One hears these days of cancer prevention and cancer detection clinics. The idea has many sound features. The problem of staffing such establishments adequately is not so great in well populated sections. But how can such clinics be staffed properly in the more rural areas where the ratio of physicians to population is much less than in the more metropolitan centers? It seems that the only possible solution today is for each physician, general practitioner or specialist, to operate his own cancer detection clinic every day in his office and on his hospital service."

Portion of a resolution unanimously adopted by the American Council of Christian Churches at Denver, Colorado, April 1949:

"Socialized medicine in any form, represents, we believe, a clear violation of the Fourth Amendment of our Constitution which guarantees 'The right of the people to be secure in their persons.'

"The battle against State medicine is not for the doctors alone, but it belongs to all Christian people who cherish their own freedom as well as the physician."

QUOTES FROM CONTEMPORARIES

The Ohio State Medical Journal has an interesting arsenal of ammunition against federalized medicine in the form of a two-page spread of short quotations, some of which are here reprinted. It will not hurt any of us to keep plenty of such "ammunition" in mind:

"Although the British people may think they are getting all this medical and dental service for nothing, somebody has to pay for it. The Ministry of Health originally had estimated the cost for the first nine months in England and Wales at \$558,000,000. But the ministry has just obtained a supplementary appropriation of \$211,200,000 . . . Where does the British government get the money to pay for these services? At least part is paid for by British taxpayers in the form of payroll deductions. But there is question as to whether the British economy could support socialized medicine without the benefits it receives in the form of Marshall Plan aid."—*Cleveland Plain-Dealer*.

"It is all very well for Great Britain and its Labor Government to install its cradle to grave security programs. It has the United States and its wealth to depend upon for loans and gifts and aid of all kinds. The United States can depend on no other nation for help." . . . —*The Columbus Dispatch*.

"The public has been led by our Socialist tub-thumpers to suppose that with the coming of the N. H. S., a medical Utopia would dawn for them. In point of fact the ordinary working-class patient is less well off than he was before the Scheme started. You will appreciate that the N. H. S. has brought no more doctors, no more nurses, no more hospital beds, and indeed, no more facilities of any kind into service with the result that there are now infinitely more people competing for the same amount of facilities . . ."—*H. A. H. Harris, Chelmsford, England*.

"Ask any G. I. how medical care on the assembly line basis works out. The hypochondriacs have a field day and those who are really sick never get to the head of the line."—*Bob Robinson in Appleton City Journal*.

"Mr. Ewing in his report charged that only 20 per cent of the American people can afford all the medical care they need. If the other 80 per cent cannot afford to pay voluntary health insurance premiums, how can they afford additional social security taxes to support more government workers."—*John L. Bach in "Pocket Medicine"*.

And here is a fundamental thought from England:

"The Law, The Church, and Medicine, should be beyond the reach of contamination of political control."—*D. R. Goodfellow, Manchester, England*.

Isn't this a lovely prospect?

"The Truman administration's vast program for national social security and medical care will, if approved by congress, cost a minimum of 12 billion dollars a year by 1955 and even more in the years to follow, congressional economists estimate.

"It is further estimated that to finance this program, the combined pay roll taxes levied on employers and workers will be increased from the present 3½ per cent to 11 per cent six years from now."—*Robert Young in the Chicago Tribune*.

We can pass such ammunition along but it is up to each doctor to fire it where it will do some good.

HOME CARE OF PATIENTS

All things seem to run in cycles, including human affairs and things medical. We now appear to have come full circle from the old days when most patients were treated at home, through the long struggle to popularize the hospital, to the present day when such a high percentage of sickness and disability is hospitalized willy nilly. But that the arc of the circle is bringing us back again to a revival of home care is well brought out in the following editorial (quoted in part) from *The Journal of the A.M.A.*, July 2, 1949:

"Home care of patients was inaugurated by the Montefiore Hospital of New York City in 1947. The program was limited to 50 patients who could not afford the services of a private physician. Ward patients who can do as well in their own homes as they can in the hospital, as determined by specially trained doctors and social workers, are returned there with a promise of complete hospital care, either in their own homes entirely or by a return to the hospital as necessary. At a later date the patient who can afford the services of a private physician but not the more expensive services which his condition demands will be included. This should result in a form of cooperation between hospital and practitioner in which the practitioner will have the diagnostic and therapeutic facilities at his disposal in the patient's home.

"A similar experiment was begun by Bellevue Hospital, New York, in 1948. Unterman and co-workers stress the importance in this program of a careful evaluation of the patient's home situation by the social worker in determining his eligibility for home care. The decision to accept a patient to home care is made jointly by the physician and the medical social worker. Nursing care is provided by the Visiting Nurse Service of New York on a fee for service basis, at the request of the home care physician. The cost of treating patients at home amounted to \$2.83 per patient day, or approximately one fourth of the cost of hospital care.

"Home care is a practical means of extending continuous medical service to indigent patients. The method results in economy of hospital beds."

Such schemes have been mentioned (and quoted) in these columns before, particularly with a view to "economy of hospital beds." Extramural care, as it is termed above, convalescent homes, or "hospitals," nursing homes for the aged, *et cetera*, all can release numbers of general hospital beds for use by the acutely ill and those actually requiring highly technical care. Such acceleration of hospital turn-over is the equivalent of building additional facilities—and much cheaper, both as to financial investment and as to need of increasing trained personnel.

As previously pointed out in this JOURNAL, county medical societies, in their capacity of the real action units of organized medicine, might do well to study the possibilities in their own communities for relieving some of the pressure on their local hospitals. Here is a field where the ideas of the smallest county society may create as valuable a contribution to this problem as that evolved by the largest societies in the U.S.A., and where the wisdom and experience of the general practitioner should rate very high.

THE HISTORICAL EXHIBIT AT THE CENTENNIAL MEETING

THURMAN B. RICE, M.D.*

INDIANAPOLIS

THERE is ever increasing need that the public understand the purposes of and the progress made by the medical profession, for it is only so that the family, the householder and the patient may cooperate with the profession in getting the best possible results from the family physician, dentist, nurse, pharmacist, health officer and sanitarian. How otherwise may the voter and taxpayer act intelligently in the matter of deciding for or against the issue so pointedly at stake, "compulsory health insurance" or "state medicine." This matter must soon be decided and by persons who are tragically poorly informed.

There is need, too, that the profession itself should be keenly aware of its own progress, of its own legitimate rights and of its own manifest destiny. Many physicians have little concept of the scientific problems that have been solved, of the ways by which we have come to our present status, and of the foundations on which we build. They think of medical practice as an accomplished fact. They are missing much when they take this view. The position in which the profession now finds itself is not a static one which is immovably fixed. It is a picture with great depth and fluidity; and can only be understood when seen in perspective and in motion.

With these basic needs concerning the profession and the public deeply appreciated, the Indiana State Medical Association plans for the annual session which will meet in Indianapolis, September 26-29, 1949. This is a very special session because it marks the one hundredth anniversary of the founding of that organization. One hundred years is a long time in so fast a flowing stream as medicine has been. What could be more appropriate than an exhibit which will demonstrate graphically the changes which have been made? What could be more dramatic, more interesting? It is hoped that every professional person and every layman will avail himself of the opportunity to see in one small area so great an accumulation of information as will there be presented.

The Historical and Scientific Exhibits will be set up together in the large Egyptian Room at the Murat Temple and will be *open to the public*. By this we mean that the public is not only *welcome*, but is most earnestly invited. Much effort is being made to insure the success of the project because we are proud of the progress made, and also because we need so badly to have the intelligent understanding and appreciation of the layman. The historical, the scientific, and the research

phases of our great medical program are put together because they represent the continuing story of the past, the present and the future of medicine. The research of a hundred years ago is now expressed in terms of the outmoded medical methods of the past, medical history indeed; the research of the turn of the century, and since, now determines present-day medical practice; the research of today will become the medical practice of tomorrow.

We shall wish to show medicine as a rapidly flowing stream—past (history), present (practice), and future (research). There will be no wish to criticize the errors of yesteryear—they were honest errors made by honest men devoted to their profession and their patients. Yes, we shall honor these men, but must emulate them only in our wish to do better as they wished to do better. We shall honor Dr. John Stough Bobbs, of Indianapolis, and seek as he did to treat gallbladder in new and better ways. It would be most absurd if we should honor him so much as to insist that his original operation was incapable of being improved, "smothering in his holy ashes . . . new-lit altar fires."

This concept of medical practice as being a flowing stream rather than a stagnant pool is one which is frequently misunderstood by the layman. He supposes that a medical fact is a hard-boiled nugget, which is true today, tomorrow and forever. He regards the physician as being incompetent when he (the physician) says that he doesn't know, or wishes to try experiments and to seek new ways which may be better ways of doing a given thing. It seems strange that doctors should disagree in their judgments. It seems that such disagreement would be dangerous to the patient. There is an old medical maxim, however, which says, "When the doctors agree the patient dies, when they disagree the patient gets well." If doctors should agree and were wrong, it really would be serious. Yes, honest doctors disagree and there are many reasons why they should do so.

The contemplation of such an exhibit as is being prepared will help the layman to *understand* why they disagree. So long as physicians are free men, well informed, honest, unregimented, and at least somewhat competitive, they will be seeking new and better ways of making diagnoses and providing treatment. So long as each is free to express his honest doubt or criticize the treatment given by a colleague we may look for continued improvement in medical practice. If the time should come when the little fellow is afraid to question the wisdom,

* Chairman, Committee on Historical Exhibits

judgment or authority of the great one, "the Commissar," then we shall quickly see a stagnation of the stream of medical progress, the Dark Ages of Medicine will be well on its way back and the shades of the long night of civilization will be very near.

The exhibit will consist of three types of demonstrations.

1. Those that are strictly scientific and attempting to explain some principle in diagnosis or treatment. Projects of this sort will mean more to the physician than to the layman, but will give the latter some idea of the complexity and interest of modern medicine.
2. Those that are purely historical and anecdotal. These will tell the story of some past person or period. They will show pictures, apparatus, books, instruments and the like, out of the past. It is only by contemplating such memorabilia that we shall be able to appreciate the long way that the state medical association and the profession have come in the century just past.
3. The largest single display will be a chronological exhibit entitled "A Century of Progress," which covers the one hundred years now closing, and shows the orderly progress

which has been made. It will consist of a table and wall display 100 feet long, plus two twelve-foot sections at the ends—a total of one hundred twenty-four feet. The central portion will consist of ten ten-foot panels representing the decades. Each section will be dated and will carry the photographs of the physicians who served as president of the state medical association during that decade, and the important medical developments of the same period. On the wall under the photographs, pictures, graphs and two-dimensional displays will be shown, while on the table below will be displayed the various three-dimensional things—drugs, instruments, models, et cetera.

In the introductory panel will be shown the background on which the state medical society was grafted in 1849, while the closing panel will suggest some of the problems of the future.

Come—professional man and layman—spend as much time as you like; study; ask questions. It is *your* medical science—*your* hope of recovery—*your* funeral, if it is allowed to deteriorate. We believe the exhibits, the relics and the opportunity to learn will be unusually interesting—excellent entertainment—and highly instructive.

PUBLIC HEALTH VS. INDIVIDUAL RESPONSIBILITY*

WALTER L. PORTEUS, M.D.

FRANKLIN

PUBLIC HEALTH is defined as the health of the community; also as the ways and means of conserving the health of the members of a community, as by preventive medicine and organized care of the sick. To reason a bit, it is a kind of community effort in which each one of us has the desire and the willingness to uphold our individual responsibility to further that cause and not delegate it completely to someone else.

In an excellent paper read before this group a year ago, Mr. Auerbach left little to be said concerning the many activities being instituted in Indiana along the lines of public health. Numerous comparisons were made percentage-wise concerning Indiana's indulgence in various phases of this work.

I shall attempt to inject a few new thoughts concerning the philosophy of public health in our state but will not burden you with statistical comparisons. It seems to be the vogue today in politico-sociological situations to come up with a type of thinking that warrants some analysis. Everyone seems to want security. The question

naturally follows: security from what? I presume that means security from lack of clothing, food, housing, good medical care and sufficient cash to obtain the other, secondary essentials of what would make a well-rounded existence.

While engaging in blissful thinking of what that word *SECURITY* means, we are quite willing to delegate the providing of that elusive commodity to a third party. Then the reasoning comes naturally that all we need to do is hire someone for pay to do the job for us. It is also in order to believe that whenever we want to improve the services of our state programs in the various categories of public health we glibly quote the amount of money spent by our sister states and the results they obtain, and then say if we would spend the same we should get similar results. Or, I suppose, to pursue that reasoning, that if Indiana, with a death rate higher than our neighboring states, would spend as much for public health as they do, we should approach their rate; and to continue, if we spent still more we could lower our rate even more. In other words, our health and our very existence depends upon how much we spend. I believe this to be a fallacious bit of reasoning after a certain practical point,

* Address of retiring president of the Indiana Public Health Association, at Indianapolis, June 28, 1949.

because it leaves out the most important element in any community enterprise. That element is the desire of individuals to lead a better and healthier life, which comes from a philosophy and a kind of teaching that can't entirely be bought with dollars.

It appears to me we have as a people advanced much more rapidly in technological aspects than we have in our moral and sociological aspects. With our great desire for security we are losing our individuality and with it our sense of personal responsibility, which is the crux of any program to better our collective lots. New movements are being initiated daily to bring bigger and better kinds of security to us all, at a price. This precious state we deem so desirable often carries the tag with the price written in an undecipherable code. Because we want it, and it sounds good, knowing what the price is is unimportant; that is, until we actually have to pay. Then, often too late, we realize that the price is personal freedom.

A great many people clamor for more money for our state institutions, not quite realizing where the necessary funds will come from and what effect it will have on some of the other necessary functions of our state government. I would say without fear of contradiction that if the total income of Indiana were spent on these institutions we could not bring the physical plants, personnel, and other agencies necessary to approximate the standards proposed by the national associations of these institutions. By way of explanation, this would mean replacement of buildings, repair on those not already firetraps, new construction to fit increasing demands, increased professional personnel and better trained attendants. Since all these elements cost money and we are already struggling under a tremendous tax burden, it behooves us to take a very sane and practical attitude about just how much we can afford to spend on each item of our public health.

Here again the slow process of education enters the picture. There is no question but that more money is spent today on such items as jewelry, cosmetics, liquor, et cetera, than is spent in relation to health. Hence it becomes a matter of priority—whether or not improving the sanitary conditions of the home or getting a new car or television is more important. There is no question that there are ever-increasing legitimate demands for additional revenue to provide for the general welfare of our people but we have reached a point when increases in the services of our government, no matter how desirable they may be, must be evaluated in the light of the burden upon the taxpayer.

If we look for all these apparently necessary items of assistance from our state or federal government we must be cognizant of the definite fact that we are not exercising the personal responsibility that goes with individual freedom. It is

this idea of something for nothing that frightens me. I believe we are each one small part of our government and I hate to be stampeded into believing that government can give us all the things we've come to believe are necessary in our places as citizens and that our individual initiative and responsibility are not very important.

There are many problems under the cover of public health that must be solved and each day seemingly brings more areas we want included. To mention only one aspect of public health, brought on by our aging population, should make one think. Better control of contagious and infectious diseases has made our people live longer, to fall prey to degenerative disease with all of its socio-economic implications. Long-term illnesses are bringing greater demands for institutions and methods for caring for these people. With their number increasing they will become a potent political block in demanding of the younger group that their care be continued and expanded. The enthusiasm provoked by the so-called Townsend Plan is an example of what could happen in our legislatures.

It is necessary that we ponder on the implications that arise from our desire to help our fellow men, when we may be weakening the strong to help the weak and thereby wrecking the whole lot. The vogue today has been to refer to the common man, and most of us will agree we are all uncommon men, at least by our own appraisal. No one as yet has had the effrontery to refer to the common woman.

We constantly clamor for more and more services from our state and federal governments, not realizing that we are literally robbing Peter to pay Paul. We *say* we want personal freedom but we *demand* government housing, hospitals, jobs and wages.

We *boast* we are aware of our personal responsibilities, but we *vote* for anyone who promises us pensions, subsidies, and free medicine.

This brings me to the conclusion that while we are all here assembled to discuss the needs for better public health in Indiana, let us not forget that to ask for too much governmental paternalism is to lose the security insured by individual freedom premised on its essential prerequisite of self-responsibility.

So remember, public health in Indiana, or anywhere, means as it must that the choice rests with each of us as individual citizens. No one can tell us what to do or think, for as responsible citizens each has obligations and privileges to follow what he considers the proper course of action—but before we act let us thoroughly understand the meaning of our actions, because public health applies to you and cannot be handed to you on a silver platter.

IS THE INDIANA 1935 STERILIZATION OF THE
INSANE ACT FUNCTIONING?

C. O. McCORMICK, M.D.

INDIANAPOLIS

A QUESTIONNAIRE recently mailed to each of the superintendents of the five state hospitals for the insane yielded the following information:

The Total Number of Admissions During 1948.

Institution A	298
Institution B	452
Institution C	279
Institution D	302
Institution E	364
Total	1,695

The Total Number of Commitments in 1948 That Were Accompanied by Court Order for Sterilization.

Institution A	0
Institution B	30
Institution C	0
Institution D	74
Institution E	51
Total	155

Total Number of Sterilizations Performed During 1948.

Institution A	0
Institution B	0
Institution C	0
Institution D	3
Institution E	0
Total	3

Do You Consider the Indiana Sterilization of the Insane Act of 1935 Adequate?

Institution A	"Yes."
Institution B	"No."

"No sterilization on account of inadequate personnel. Also, recent statistics show that the necessity for sterilization has been greatly over-emphasized."

Institution C	"Yes."
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"The chief difficulty is in obtaining available funds to pay for sterilization."

Institution D	"Yes."
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"I consider the Indiana Sterilization Act adequate. We have been able to do a great many under it. Some judges will not sign the order in any case and others sign them in perfectly useless cases, aged, etc. This act can and will answer the purpose admirably."

Institution E	"No."
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"There has not been a sterilization at this hospital for at least three years. I am trying to get some lined up now. We wrote asking permission from a judge who has not answered us.

"The procedure seems confusing since the new law has the court and the examiners initiate the process. These examiners may not be skilled in psychiatric diagnosis and able to adequately judge when sterilization is necessary. In many states the superintendent starts the procedure and the hearing is held before the court or board of medical examiners.

"If there is only going to be one method of initiation it would be better from the hospital as there is more history material and greater opportunity for observation by experts.

"In Indiana the superintendent has two governing boards, the immediate board of controls and the Indiana Council for Mental Health. In a case we had recently we requested the judge's permission and there has been no answer. Now if we can go by the old law and initiate the action according to the proceedings stated therein, is it enough for the Board of Control to approve or should it go through the Council, or both? There are patients here who could go out but I am holding them until they are sterilized, both from the viewpoint of the patient and the potential offspring as another pregnancy would undoubtedly precipitate another episode.

"In the case under question the court and the committing physicians would not take the action. The court is not cooperating and in cases where there are no nearest of kin a legal guardian would have to be appointed by the committing court. I think this is a matter for which the Council and your committee could work out a procedure. I would be glad to have any comments you may have.

"Another question—Routinely where the court has not given permission and nothing is said about it, should we proceed under the old law or contact the judge for his permission?"

THE ACT

(H. 490. Approved March 13, 1935.)

AN ACT providing for the sexual sterilization of insane persons in certain cases, prescribing the powers of courts, and defining the duties of medical examiners and superintendents of institutions for the insane in relation thereto.

Section 1. Be it enacted by the general assembly of the State of Indiana, That whenever an application for the commitment of any person to an institution for the insane shall be filed in any court having competent jurisdiction, it shall be the duty of each of the examining physicians appointed by the court, as now provided by law, if he shall certify to the court that the person for whom such

application is made, is, in his opinion, afflicted with insanity, to further certify to the court whether, in his opinion, such person is the probable potential parent of mentally incompetent or socially inadequate offspring likewise afflicted.

Section 2. Upon the hearing of such application for commitment, evidence may be submitted as to whether the best interest of society and of such insane person will be served by his or her sexual sterilization; and if the court shall find that such person is insane and should be committed to the custody of such institution for the insane, it shall further find whether the welfare of society and of such insane person will be promoted by his or her sexual sterilization, the finding of the court being either that sexual sterilization is unnecessary or that the best interest of society and of such insane person will be served by his or her sexual sterilization. And if the court shall find that the best interests of society and of such insane person will be served by his or her sexual sterilization, the court, as a part of the judgment and decree committing such insane person to such institution, shall authorize the superintendent of the institution to which such insane person is committed to have performed upon such insane person the operation of vasectomy, if a male, and of salpingectomy, if a female, or any other more suitable operation or treatment having full sterilizing results, which authorization shall be set forth in the order of commitment, a copy of which, under the seal of the court, shall be forwarded to such superintendent along with other required papers in the case. Such insane person, by his or her guardian, parent or next friend, may, within thirty days after judgment, appeal as in other civil proceedings, from the finding and judgment of the court authorizing such operation of sterilization, and the pendency of such appeal shall stay the performance of such operation of sterilization until the appeal be determined. Upon the filing of notice of appeal, the clerk of the court in which such notice is filed shall forthwith forward by mail to the superintendent of such institution, written information of the filing of such notice of appeal.

Section 3. Whenever any insane person upon whom the operation of sexual sterilization shall have been authorized, as herein provided, shall have been admitted to an institution for the insane, the superintendent thereof, at such time as he may deem expedient and when in his judgment the general health of such insane person will not be affected thereby, and not less than thirty days after

such insane person has been received at such institution, shall have performed upon such insane person, by a competent and licensed physician and surgeon, the operation of vasectomy, if a male, and salpingectomy, if a female, or any other more suitable operation or treatment having such sterilizing results.

Section 4. It shall be the duty of the superintendent of such institution for the insane, whenever an operation for the sexual sterilization of an insane person shall have been performed, under the provisions of this act, and within ten days thereafter, to make a report thereof to the secretary of the department of public welfare, or its successor, which report shall set forth the name and age of the person upon whom such operation was performed, the county from which such person was committed, the date of such commitment, the date of admission to the institution, and the date of such operation.

Section 5. Neither the superintendent, nor the attending physician or surgeon, nor any other person legally participating in the execution of the provisions of this act shall be liable civilly on account of such participation.

Section 6. The provisions of this act shall not be construed as conflicting with nor superceding the provisions of the act approved March 11, 1927, entitled "An act to provide for the sexual sterilization of inmates of state institutions in certain cases," which act shall remain in full force and effect, but are intended as a separate and additional method of procedure.

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The evident failure of the law must baffle those who had considered such legislation competent to assist materially in reducing the state's "load." Particularly is it disappointing to those who are impressed by the growing inadequacy of the present five institutions; an inadequacy that is necessitating the building of a sixth institution at an outlay of \$20,000,000, and has incurred an overall burden sufficient to curtail to a detrimental degree current financial support of our Indiana University Medical Center.

It would appear that if such legislation is meritorious and is to endure, the present law either will have to be more effectively executed, or grossly amended—most likely the latter. Among other recommendations it has been suggested that its application should not be limited only to state hospitals but to private institutions as well.

Have You Selected Your Classes in the Instructional Courses
Listed on Page 950?

BLUE SHIELD PLANS APPROVE NATIONAL ENROLLMENT AGENCY

AFTER receiving a report from the Council on Medical Service of the American Medical Association, implying that Associated Medical Care Plans might soon be free to establish its own national enrollment agency, the 1949 Annual Conference of Blue Shield Plans voted on April 19, 1949, to establish such an agency, to be known as the Blue Shield Health Service, Inc.

After several years of study, marked by serious debate during recent months, Blue Shield Plans cast a weighted vote of 173-21 in favor of establishing a national enrollment agency to be controlled by Blue Shield Plans and the medical profession.

The present proposal is a modification of one previously turned down by the AMA House of Delegates, in which Blue Shield and Blue Cross would have united their efforts in a jointly-owned enterprise. Blue Cross, in the meantime, has proceeded with its own plans to establish a Blue Cross Association and a Blue Cross Health Service, Inc.

In accordance with the resolution and proposal adopted by Blue Shield at its annual conclave in Hollywood, Florida, on April 18-20, 1949, the Blue Shield Health Service, Inc., would be incorporated as a separate entity, after which contractual agreements with the corresponding Blue Cross organization might be effected for purposes of offering medical and hospital protection to the public in one package.

The proposal calls for contributions to capital funds from the local Blue Shield Plans, the required minimum being \$375,000 and the maximum \$500,000. Contributions would be made directly to Associated Medical Care Plans for the purpose of either purchasing the entire stock or supplying the capital funds needed for launching Blue Shield Health Service, Inc.

The suggested composition of the Board of Directors would include representatives of the contributing Plans, the Blue Shield Commission, and the American Medical Association, although the exact ratio of representation was not determined in the proposal as adopted by the Plans at the annual conference.

Chief among the functions to be performed by such an agency would be the coordination of Blue Shield enrollment when dealing with national accounts, which are defined as groups of employees working for firms with locations scattered throughout the country in a way which prevents any one Blue Shield Plan from serving the entire group.

A copy of the actions taken by Blue Shield was mailed on May 6 to each member of the AMA House of Delegates for their information, inasmuch as the Blue Shield Commission was instructed to delay implementing the proposal until after it had

been considered by the American Medical Association. The ratification of a majority of the governing boards of Blue Shield Plans will be required, also, before the Blue Shield Commission may proceed to solicit funds for the establishment of such an enrollment agency.

**A.M.A. HOUSE OF DELEGATES APPROVES
SEPARATION OF A.M.A. AND A.M.C.P.**

Complete separation of the American Medical Association and Associated Medical Care Plans was approved by the AMA House of Delegates at its 98th Annual Session in Atlantic City, meeting from June 6-9, 1949.

Recommended originally by the Council on Medical Service of the AMA, in a statement delivered to the Blue Shield Commission of AMCP at its meeting in Hollywood, Florida, on April 15, 1949, the separation was accepted by the Blue Shield national organization before the question was placed before the AMA House of Delegates.

E. Vincent Askey, M.D. (California), chairman of the reference committee to which the Council's recommendation was referred, in commenting on the committee's report, said, "Your reference committee feels that it is important that the delegates read carefully the comment of the Council on Medical Service, appearing in the second paragraph of its recommendation, so there may be no misunderstanding as to the value attached to the accomplishments of AMCP."

The statement referred to in Dr. Askey's word of caution said, "The Council on Medical Service desires at this time to acknowledge the efforts of AMCP in promoting through its member plans the principle of voluntary prepayment health insurance; and believes that AMCP has reached a state of development where it can function more adequately as an autonomous trade association."

In approving another resolution, introduced by L. Howard Schriver, M.D. (Ohio), the House of Delegates pledged its support to AMCP as an independent federated agency representing state and local Blue Shield Plans.

It was commonly agreed, by all concerned, that one of the reasons for the separation of these two organizations had been an inability to agree upon a Blue Shield proposal to establish a national enrollment agency for handling so-called national accounts. The dilemma was bridged by adoption of the Schriver resolution, which "FURTHER RESOLVED that the several state and local Blue Shield Plans continue the development of an enrollment agency to act in their interest in the field of so-called 'national accounts,' using their best

judgment (and that of sponsoring societies) with respect to the methods, means, procedure and form of organization by which the problems related to national accounts may be solved."

Five members of the Blue Shield Commission originally appointed by the Council on Medical Service were invited by the Commission to continue their membership as individuals, even though they no longer represented the AMA. The five Commissioners include Drs. A. W. Adson, Elmer Hess,

Charles Gordon Heyd, J. D. McCarthy, and Carl F. Vohs.

Leaders in the Blue Shield movement accepted the change in status as an indication that AMCP had matured to the point where it could function, move efficiently as an independent trade organization, and without official relationship to the AMA. A situation which had become highly controversial was resolved to the apparent satisfaction of everyone involved.

Deaths

Martin Bernard Strange, M.D., of New Albany, died suddenly on July 15. He was forty-two years of age. A graduate of Indiana University School of Medicine in 1937, Doctor Strange began the practice of Medicine in New Albany the following year. During World War II he served as a lieutenant in the Medical Corps. He was a member of the Floyd County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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J. Clifford Wallace, M.D., of Fort Wayne, died on July 13, at the age of seventy-three. He graduated from the Fort Wayne College of Medicine in 1898, and from the Rush Medical College in 1900. He had specialized in obstetrics, and was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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William T. Hargis, M.D., of Tell City, died on July 8, at the age of eighty-four. A graduate of the University of Louisville School of Medicine in 1894, Doctor Hargis began the practice of medicine in Derby, where he practiced for eleven years, before going to Tell City, in 1905, where he had practiced continuously until a few weeks before his death. He was an honorary member of the Perry County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

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George F. Knue, M.D., of Indianapolis, died on June 25, at the age of sixty-four. He was a graduate of Indiana University School of Medicine in 1909, and had been an industrial surgeon in Indianapolis for forty years.

George W. Grossnickle, M.D., of Elkhart, died suddenly on July 27, at the age of sixty-nine. He was a graduate of the University of Michigan Medical School, in Ann Arbor, in 1909, and practiced in North Manchester for four years, before going to Elkhart in 1913, where he had practiced ever since. Doctor Grossnickle was a member of the Elkhart County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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Elizabeth Miller, M.D., retired physician, died at Indianapolis on August 10. She was eighty-eight years of age. Doctor Miller graduated from the Eclectic Medical College, in Cincinnati, in 1891, and practiced for many years at Anderson.

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William J. Tolliver, M.D., who formerly practiced in Elnora and Anderson, died in Atlanta, Georgia, on August 1, after a long illness. He was seventy-five years of age. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1892.

* * *

Etta Charles, M.D., of Anderson, died on July 16, after a long illness. She was eighty-eight years of age. Doctor Charles was a graduate of the St. Louis Woman's Medical College, in 1895, and had specialized in anesthesia. She was an honorary member of the Madison County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

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Ernest Cooper, M.D., retired physician of Plainfield, died on July 16 at Miami, Florida, where he had lived for the past fourteen years. He was seventy-nine years of age. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1898, and had practiced in Hendricks County for more than thirty-five years.

News Notes

TENTH DISTRICT MEETING

The date and place of meeting for the Tenth Councilor District has been changed. It will be held at 6:00 p.m., at the Marshall House in Gary, on October 11. The guest speaker for this meeting will be Paul R. Hawley, M.D., Chief Executive Officer of Blue Cross—Blue Shield Commissions, whose subject will be "Government Medicine." Members of the Dental Association, lay guests, and newspaper and radio representatives have been invited to attend, because of the general interest in Doctor Hawley's address.

INDIANA UNIVERSITY POSTGRADUATE COURSES

Indiana University School of Medicine has announced definite dates for two of its postgraduate courses this fall.

The Course in Obstetrics and Gynecology will be conducted for five full days, November 14 through 18, on the same general plan which was used for a similar meeting last year. Instruction will be given in clinics, both operative and medical, in ward rounds, and in lectures. A fee of \$50.00 will be charged.

The Pediatrics Postgraduate Course will be given on four Wednesday afternoons, November 2, 9, 30 and December 7. Clinics, lectures and demonstrations will be utilized. The fee for the course will be \$5.00 per day.

Enrollment for each course is limited to 30. Interested physicians are urged to enroll as soon as practicable. Inquiries may be directed to The Dean, Indiana University School of Medicine, Indianapolis.

A.M.A. INTERIM SESSION

Plans are moving ahead to make the Clinical or Interim Session of the American Medical Association, which will be held in Washington, D. C., December 6-9, the best ever.

Recommendations have been made for a coordinated plan of streamlining the scientific program so it will be especially attractive to general practitioners living in and around the nation's capital.

Promotional mailings to physicians within a 500 mile radius of Washington are being planned. At least two, or probably three, mailings will be made to doctors between now and the session. These mailings will include a brief outline of the program, and blanks for making hotel reservations and registering in advance. Every effort will be made to develop a good attendance—one that will surpass the two previous sessions which were held in Cleveland and St. Louis.

ELEVENTH DISTRICT MEETING

The Eleventh Councilor District Medical Association will meet in Delphi on Wednesday, September 21. The business and scientific program will be held in the Delphi Armory, beginning at 2:00 p.m. There will be a "Hobby Exhibit" on the second floor of the Armory. The scientific program will consist of: "The Inaugural," by F. M. Whisler, M.D., Wabash; "Differential Diagnosis of Lesions of the Knee, With Negative X-rays," by James K. Stack, M.D., Associate Professor of Bone and Joint Surgery, Northwestern University, Chicago; "Neoplasms of the Head and Neck," by Brice E. Fitzgerald, M.D., Logansport; "Uses and Abuses of the Antibiotics," by R. A. Solomon, M.D., Indianapolis.

The evening meeting will be held at 6:30 in the Masonic Temple. The guest speaker will be Dr. George E. Davis, Director of the Office of Student Affairs of Purdue University, who will speak on "Riley."

DATES SET FOR ANNUAL A.M.A. PUBLIC RELATIONS CONFERENCE

The second annual A. M. A. Public Relations Conference will be held in Chicago on November 5 and 6, immediately following the Secretaries and Editors Conference, November 3-4.

Lawrence Rember, director of the A. M. A. Public Relations Department, said this year's PR meeting will be built around the doctor who is serving as public relations chairman of his state society.

"The meeting," Mr. Rember said, "will provide him an opportunity to exchange ideas and to present and receive information pertinent to his activities and responsibilities."

As a result of the success of the one-day PR conference in St. Louis last November, this year's meeting has been expanded to a day and a half, opening the morning of Saturday, November 5, and closing with a luncheon on Sunday, November 6.

Invited to the conference, which was authorized by the A. M. A. Board of Trustees, will be public relations committee chairmen, executive secretaries, and public relations directors of state medical societies and of county medical societies which maintain executive offices. Some state presidents and other public relations staff members undoubtedly will attend as they did in St. Louis.

Dr. Earl W. Mericle, of Indianapolis, was recently appointed chairman of the Indiana Council for Mental Health by Governor Henry F. Schricker. Doctor Mericle has been practicing psychiatry in Indianapolis since 1936, and has been a member of the neuropsychiatric staff of Indiana University School of Medicine since 1937.

Formerly associated with the VA Cold Springs Road Hospital, in Indianapolis, **Dr. Louis M. Sales** is now with the VA center at Bath, New York, as chief medical officer. Prior to going to New York, Doctor Sales was with the VA Hospital at Lake City, Florida.

Dr. Horace O. Norton has announced the opening of an office in Washington for the practice of medicine. A 1942 graduate of Indiana University School of Medicine, he served his internship at St. Vincent's Hospital in Indianapolis, and then spent thirty-eight months with the Medical Corps of the Army, with service in England and France. Following his separation from service, Doctor Norton practiced medicine for three years in Crane.

Dr. Jean W. Morris, formerly of Hartford City, has opened an office at 247 Johnson Building, in Muncie, for the practice of ophthalmology.

Doctors Oran and William Province, of Franklin, recently announced the association with their office of **Dr. Donald Manuel**, of Louisville, Kentucky. He is a graduate of the University of Louisville School of Medicine, in 1946, and served his internship at Presbyterian Hospital in Chicago. Doctor Manuel served with the United States Army from 1947 to 1949, during which time he served at Fort Knox, Kentucky, and in Frankfurt, Germany, with the 97th General Hospital, where he was assistant chief of medical service. While in Europe he took postgraduate work in internal medicine at the University of Vienna.

Dr. John T. Parker, of Gary, has accepted a position as chief of the eye department at the Lovelace Foundation in Albuquerque, New Mexico.

As a result of his appointment to the senior surgical residency at Nichols Veterans Hospital, in Louisville, **Dr. Edward J. Sharman** has entered the hospital, for a two-year postgraduate course in surgery. He will retain his office in Madison, however, and upon completion of the course will resume full practice in Madison.

Dr. Robert O. Zink, of Vevay, has moved to Madison, to become associated in practice with **Drs. Lewis E. Jolly, Jackson Modisette and Marcell Modisette** there. Doctor Zink's practice in Vevay will be taken over by **Dr. Harold Griffith**, who has recently been separated from service.

The community of Cicero paid tribute to **Dr. C. H. Tomlinson** on July 29, which was designated as "Doctor Tomlinson Day," in appreciation of his service to that community for more than fifty years. He began the practice of medicine in Cicero in 1895, and in addition to serving the community in a medical capacity, has been a leader in its civic affairs. He is an honorary member of the Hamilton County Medical Society.

Formerly chief resident at Methodist Hospital, in Indianapolis, **Dr. David Joe Smith** is now associated in practice with **Drs. W. D. Gatch and John Owen**, in the Hume Mansur Building, in Indianapolis. A graduate of the Indiana University School of Medicine in 1942, Doctor Smith served for thirty months in the Army, which included a year's service in the European Theater. He was a major at the time of his separation from service.

Dr. Herbert L. Joseph has established a practice in dermatology in Vallejo, California, after completing postgraduate training at the Barnard Free Skin and Cancer Hospital, in St. Louis.

A 1944 graduate of Indiana University School of Medicine, **Dr. Floyd W. Mohler** is now in practice with **Dr. Harry Kitterman**, at 510 Hume Mansur Building, in Indianapolis. Doctor Mohler recently completed an orthopedic residency at the Methodist Hospital in Indianapolis.

Dr. William M. Matthews is now practicing medicine with his father, **Dr. B. J. Matthews**, at 4612 East 10th Street, in Indianapolis. Dr. William Matthews recently completed a long tour of duty in the Army.

Dr. Robert F. Cavitt has opened an office in Connersville, for the practice of medicine. A 1948 graduate of the University of Kansas Medical School, Doctor Cavitt interned at the Indiana University Medical Center.

Dr. Davis W. Ellis, Jr., a 1947 graduate of Indiana University School of Medicine, has opened an office in Rushville for the general practice of medicine. Doctor Ellis was formerly associated with **Dr. Eugene Boggs**, in Indianapolis.

Dr. William J. Calvy is now associated with the Johnston-Gendel Clinic in Anaheim, California, specializing in ophthalmology. A 1939 graduate of the University of Wisconsin School of Medicine, Doctor Calvy was located with **Drs. Sputh and Sputh** in Indianapolis. He is a World War II veteran, with more than three years' service.

Dr. A. Dale Slater, of Louisville, has opened an office for the practice of medicine in Scottsburg.

Dr. Renè A. Desjardins, of Salem, Massachusetts, recently began a residency in medicine at St. Elizabeth Hospital in Lafayette. He had just completed a two-year assignment as a medical officer in the Navy. Doctor Desjardins is a graduate of Tufts Medical School, in Medford, Massachusetts, in 1946, and served his internship at Salem Hospital in Salem, Massachusetts.

Dr. Charles Deppe has moved to Franklin, where he is associated in the practice of medicine with **Dr. Lyman D. Eaton**. For the past two years Doctor Deppe has been practicing in Edinburg, prior to which he served for four years in the Navy.

Dr. Ray T. Foster, of Indianapolis, has opened an office in New Castle for the practice of surgery. He is a graduate of the St. Louis University School of Medicine, and served his internship at Indianapolis General Hospital, where he also practiced surgery for four years. He is a veteran of World War II, having served for two and one-half years in the Southwest Pacific.

Dr. James Higgins, of Otwell, has taken over the office of **Dr. Richard Fowler** in Petersburg, following Doctor Fowler's accepting a practice in Bloomington. A recent graduate of Johns Hopkins Institute, Doctor Higgins practiced in Otwell, before moving to Petersburg.

Dr. Paul McGuff has opened an office for the practice of surgery, gynecology and proctology at 605 E. Maple Road, in Indianapolis. A graduate of Indiana University School of Medicine in 1944, Doctor McGuff received his M.S. degree from the Mayo Clinic, University of Minnesota, in December 1948.

Announcement was made recently that **Dr. Richard A. Brickley** and **Dr. William F. Oren** have become associated in the practice of medicine and surgery in Bluffton with Doctor Brickley's father, **Dr. H. D. Brickley**, and **Drs. C. H. Mead, O. G. Hamilton** and **A. F. Keller**. Dr. Richard A. Brickley is a graduate of Northwestern University School of Medicine in 1947, and Dr. Oren is a graduate of Harvard Medical School in 1947.

Dr. Frank K. Daugherty is now practicing medicine with **Dr. Robert M. LaSalle**, in Wabash. Doctor Daugherty is a graduate of Indiana University School of Medicine, and spent his internship at Christ Hospital, in Cincinnati.

Discharged from the U. S. Navy May 1, 1949, **Dr. Stanton E. Cope** has opened an office for the practice of medicine in Huntington. A graduate of Indiana University School of Medicine in 1946, Doctor Cope interned in the Naval Hospital in San Diego, California, for two years, and then went to the island of Saipan.

Dr. Robert B. Acker, of South Bend, was appointed recently by Governor Schricker as chief of staff of the Northern Indiana Crippled Children's Hospital Board, at South Bend. An orthopedic surgeon, Doctor Acker was active in the campaign for construction of the hospital. The hospital, which was completed August first, will be ready for occupancy about October first.

Formerly of California, **Dr. Robert F. Cavitt** has become associated in the practice of medicine with **Dr. F. B. Mountain** at Connersville. Doctor Cavitt is a graduate of the University of Kansas Medical School, and served for three and one-half years in the Army. He recently completed postgraduate training at the Indiana University Medical Center. Doctor Cavitt and Doctor Mountain, who has practiced in Connersville for thirteen years, have opened new offices at 930 Central Avenue in Connersville.

Dr. Madeline P. Dublin, of Canton, Ohio, has opened an office for the practice of medicine in Francesville.

Formerly of Indianapolis, **Dr. Samuel Geller** has moved to Owensville and is associated in the practice of medicine there with **Dr. J. R. Montgomery**.

A former resident of Fremont, **Dr. John J. Hartman** is now associated in the practice of medicine and surgery with **Dr. K. L. Kissinger**, in Angola. Doctor Hartman is a graduate of the University of Michigan School of Medicine.

Announcement has recently been made of the opening of an office in Greenfield for the general practice of medicine by **Dr. Ryland Roesch**. A graduate of the Indiana University School of Medicine, Doctor Roesch served his internship at St. Vincent's Hospital, in Indianapolis. During World War II he served with the U. S. Army Medical Corps in the Pacific area.

Dr. Robert C. Reed is now associated in the practice of medicine with **Dr. C. L. Luckett**, at Terre Haute. A graduate of Indiana University School of Medicine, Doctor Reed interned at Indianapolis General Hospital.

Dr. John R. Wagoner has opened an office at Colburn for the practice of medicine. He is a graduate of the Western Reserve College at Cleveland, and spent his internship at St. Elizabeth Hospital in Lafayette.

AID FOR POLIO VICTIMS

The crippled children services of the State Department of Public Welfare are available to family physicians in suspected or actual cases of infantile paralysis. Representative pediatricians and orthopedists in all parts of the state are ready to respond, and may be procured by contacting the local welfare department. Field services, including physiotherapy, occupational therapy and orthopedic nursing, of the State Welfare Department are also available to attending physicians on their prescription.

SEAL OF ACCEPTANCE

The AMA Council on Medical Service has awarded the Seal of Acceptance to four more voluntary prepayment medical care plans. This brings the total number of "accepted" plans to seventy. The four newly accepted plans are:

Arkansas Medical & Hospital Service, Inc.

Eastern Idaho Medical Service Bureau (Idaho Falls).

New Mexico Physicians Service.

Medical Service Bureau of the Utah State Medical Association, Inc.

EVANSVILLE BLUE-CROSS SHIELD COMMUNITY ENROLLMENT

Evansville now claims the distinction of being the largest city in the country that has put every agency of the community behind a combination Blue Cross-Blue Shield community enrollment.

The people of Evansville completed an unusually successful community-wide enrollment last month. The services of Blue Cross-Blue Shield membership are now available to nearly 10,000 individuals who could not have joined through other means. These people, not employed in groups of five or more, are only eligible for enrollment during a community campaign. As members, they and their dependents receive the same services as the employee members of 562 Evansville firms.

There are no age limits and no physical examination is required.

At the end of June more than 50,000 Evansville residents were qualified to receive the hospital and surgical services of Blue Cross and Blue Shield. Area membership has almost doubled since May of this year. On July 1, the official closing date of the Evansville campaign, a large number of applications from employees of local companies were still being processed as new group enrollments may be started at any time.

Public response to the community enrollment indicates that a majority of Evansville's citizens are glad to be able to meet unpredictable hospital, surgical and obstetrical bills by the prepayment of small membership fees. The city has taken voluntary action through the non-profit Blue Cross-Blue Shield organization to solve the medical expense problem and to strengthen its own hospital and health building facilities.

—Health Bank Notes, July, 1949.

MEDICAL ADVISER NAMED

Guy W. Spring, Executive Director of the Indiana Blue Cross Plan for Hospital Care, announces that Dr. James M. Smith has been named Medical Adviser to the Plan. Determination of medical questions arising in connection with hospital admissions will be Dr. Smith's responsibility.

Formerly medical director of the Indianapolis Life Insurance Company, Dr. Smith is a native of Ohio and holds degrees from Kenyon College and the Indiana University Medical School. For the past seven years, Dr. Smith has also served as Health Officer of Brown County, where he makes his home.

CANCER RESEARCH GRANTS

National Cancer Institute grants of \$1,026,294 to finance laboratory and clinical research in cancer have been announced by Oscar R. Ewing, Federal Security Administrator.

The grants were approved by Surgeon General Leonard A. Scheele of the Public Health Service following recommendation by the National Advisory Cancer Council, at a meeting earlier this month.

Several of the grants will carry forward investigations of the "milk factor" which causes breast cancer in mice. There is no experimental evidence at present for the existence of a "milk factor" in human cancer.

The hypotheses that cancer may be due to a change in the genes, or a mutation of the cells, are still being actively explored in many laboratories. Dr. H. J. Muller of Indiana University, at Bloomington, has received a continuation grant for three years to continue his experiments in producing cell mutations by ultraviolet light. Doctor Muller was one of the first to produce mutations in the cell by x-rays. The theory that ultraviolet light can produce mutation has previously been demonstrated on cells of molds and bacteria. Doctor Muller will experiment with the fruit fly, *Drosophila*, to find under what conditions the highest number of cell mutations are obtained, and will consider mutations in relation to dosage, wavelength, season of the year, and the angle at which the egg is penetrated by the light.

Three other Indiana physicians have also received grants. Dr. Edward W. Shrigley, of Indiana University, Bloomington, received \$6,480 for the studies of the effect of virus infection on chick embryos by use of radioactive isotopes. Dr. John H. Van Dyke, of Indiana University, Bloomington, received \$7,668 for the study of extrinsic factors influencing abnormal development in mammals. Dr. Kenneth N. Campbell, of the University of Notre Dame, received \$7,200 for the study of the synthesis of possible chemotherapeutic agents for cancer.

The National Gastroenterological Association will hold its 14th Scientific Session at the Somerset in Boston, on October 24-26, 1949. Among the outstanding speakers to present papers at the convention are Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School; Dr. Frank Lahey, Lahey Clinic, Boston; Dr. William B. Castle, Boston; Dr. George Crile, Jr., Cleveland; Dr. Maxwell Finland, Boston; Dr. J. M. T. Finney, Jr., Baltimore; and Lord Alfred Webb-Johnson, President of the Royal College of Surgeons, London, England, who will be a guest of honor at the banquet to be held on Tuesday evening, October 25, 1949.

At the Annual Banquet to be held at the Somerset, the winner of the National Gastroenterological Association's 1949 Prize Award Contest for the best unpublished contribution on Gastroenterology or an allied subject, will receive the prize of \$100 and a Certificate of Merit.

Immediately following the Convention on October 27, 28, 29, 1949, the Association is sponsoring a course in Gastrointestinal Surgery at the Boston City Hospital.

Further information concerning the program and details of the course may be obtained by writing to the Secretary, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Completion of an intensive four-week advanced training course in occupational therapy for 12 women who are already national leaders in the profession was announced recently by the University of Southern California.

The dozen therapists came to SC on scholarships from the National Foundation for Infantile Paralysis, which selected them as a group to speed the training of other therapists throughout the nation to work with polio victims.

Helen L. Hopkins, of Riley Hospital, Indianapolis, was one of the 12 students enrolled in the course.

Allocation of \$1,650,173 from the state cigarette tax fund was made recently, for completion of the Larue D. Carter Mental Screening Hospital on the Indiana University Medical Center campus. An additional \$500,000 was allocated for improvement of facilities at several state institutions. Payment of \$408,000 on the existing building contract for construction of the \$18,000,000 Northern Indiana Mental Hospital at Westville was approved. The State Budget Committee also allocated \$79,000 for remodeling dormitories and \$6,500 for improvements of the physicians quarters at Madison State Hospital. A \$20,000 appropriation was granted the Southern Indiana Tuberculosis Hospital at New Albany for repairs.

The Central State Hospital of Indianapolis will be on the program of the International Neurological Congress, to be held in Paris, France, September 5-10, 1949, Dr. Max A. Bahr, Superintendent, has announced.

The institution is represented with two papers, one dealing with "The Pathogenesis and Treatment of Syphilitic Optic Atrophy." The second is on the following subject: "Late Central Nervous System Sequelae of Rheumatic Fever." The papers are supplemented by scientific exhibits of the same titles.

No state funds are used in connection with the hospital's participation in the Paris meeting. The material will be presented by Dr. Walter L. Bruetsch, the hospital's clinical and research director, "on his own."

INTERNATIONAL EXCHANGE OF PUBLICATIONS

Unesco proposes to publish later in the year a Manual on the International Exchange of Publications.

It is intended to publish as an annex to this manual a classified list of institutions, including libraries, universities, scientific institutions, learned societies, etc. throughout the world, which are willing to exchange either their own publications or other publications which they have regularly at their disposal. In the course of its activities Unesco has been able to obtain a considerable amount of information concerning the availability of exchange material, but we feel that the information at our disposal is still far from complete. All institutions which have so far not sent to Unesco details of their exchange material in one form or another are therefore urged immediately to communicate the following information to the Unesco Clearing House for Publications, 19 Avenue Kléber, Paris, 16e:

- (a) Name and full address of institution.
- (b) Exact titles of publications offered. (In the case of duplicates offered for exchange purposes actual lists of duplicates are not required, but only a statement that lists of duplicates are available. Institutions possessing a catalogue of their own publications available for exchange are asked only to send a copy of the catalogue or to give a full bibliographical description of the catalogue.)
- (c) Institutions which wish to exchange their publications only under certain conditions, are asked to state what these conditions are.

Only information which reaches Unesco before October 1st, 1949 can be used in the Manual and it is therefore in the interests of all institutions concerned to communicate immediately with the above address.

The twenty-eighth annual **Hospital Standardization Conference** will be held at the Stevens Hotel in Chicago, October 17 to 21, as a part of the thirty-fifth Clinical Congress of the American College of Surgeons. Several hundred hospital executives from the United States, Canada, and other countries are expected to attend.

The opening session on Monday, October 17, will be a general assembly for surgeons and hospital representatives, with Dr. Dallas B. Phemister of Chicago, President of the College, presiding.

Speakers will include: Dr. Irvin Abell of Louisville, Chairman of the Board of Regents; Dr. Harrison Ray Andersen of Chicago, Pastor of the Fourth Presbyterian Church; Rev. John W. Barrett of Chicago, President, Catholic Hospital Association; George Bugbee of Chicago, Executive Director, American Hospital Association; Dr. Paul B. Magnuson, Washington, Chief Medical Officer, Veterans Administration.

For details of the program, write to L. G. Jackson, Director, Department of Public Relations, 40 E. Erie Street, Chicago 11.

ARMY SELECTS 486 NEW DOCTORS FOR INTERN TRAINING

A total of 486 medical school graduates and senior medical students have been selected for the Military Intern and Civilian Intern Programs, and began their internships and training on July 1, it was announced by Major General R. W. Bliss, Surgeon General of the Army.

Commissions as first lieutenants in the Medical Corps Reserve have been given to 231 medical school graduates who will be assigned to Army general hospitals taking part in the Military Intern Program. These internships are offered each year by the Army to selected graduates of medical schools approved by the American Medical Association. Appointments begin on July 1 of each year and terminate June 30 the following year. Commissions in the Regular Army are tendered to some at the close of the year.

Twenty-four of those selected for the Military Intern Program formerly held Reserve Corps rank in the Army, Navy, or Air Force.

Selected for commissions as first lieutenants in the Medical Corps Reserve and assignment to civilian hospitals for intern training in the Civilian Intern Program beginning July 1 are 255 medical school senior students. This program is designed primarily for young physicians who desire a career in the Regular Army Medical Corps. Applicants must have been accepted for internship training in a civilian hospital approved by the American Medical Association. Physicians selected for training under this program are required to serve two years on a duty status upon completion of their year of intern training. During this year of training they are officers on active duty with full pay and allowances of the grade of first lieutenant.

ARMY BEGINS JOINT STAFFING OF NAVAL HOSPITALS

Joint staffing of four Naval hospitals with Army medical personnel at St. Alban's Hospital, Long Island, New York; Corona and Long Beach Hospitals, California; and Portsmouth Hospital, Portsmouth, Virginia, has been announced by Major General R. W. Bliss, the Surgeon General of the Army.

The joint staffing of military hospitals was recommended by the Hawley Board in January of this year in order to economize to the fullest extent possible on physicians and other scarce professional personnel and to reduce the number of hospitals. Under the plan, hospitals of the respective services allocate a certain number of beds for patients from other services. A total of 825 beds has thus been made available in these four hospitals for Army and Air Force patients.

Nine Army Medical Corps officers, including a pediatrician, an internist, a general surgeon, an orthopedic surgeon, and five general duty physicians, were assigned to St. Alban's Hospital, which has allocated 450 beds to Army and Air Force patients. Allocation of these beds made it possible for the Army to close Fort Totten General Hospital, Long Island, and to reduce Tilton General Hospital, Fort Dix, New Jersey, to station hospital status, effective June 30.

Three Army Medical Corps officers in residency training have been assigned to Portsmouth Naval Hospital, which has allocated 100 beds to the Army and Air Force.

At Corona and Long Beach Hospitals, a total of 300 beds have been turned over to the Army and Air Force, making it possible to close McCornack General Hospital June 30. An internist, a general surgeon, and a general duty physician are being assigned to each of these hospitals by the Army Medical Department.

Members of the Dental Corps, Army Nurse Corps, Medical Service Corps, and Women's Specialist Corps and enlisted personnel are being assigned to these hospitals in proportionate numbers to help with the work load of all patients and augment the hospital staff.

In a similar joint staffing procedure, the Navy recently assigned personnel for duty at the Army's Tripler General Hospital at Honolulu, Hawaii, where all Naval patients in the islands are now hospitalized.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

July 31, 1949

The Council of the Indiana State Medical Association convened for its summer meeting at 10:20 a.m., daylight saving time, Sunday, July 31, 1949, in the Harrison Room, Columbia Club, Indianapolis, with Dr. Alfred Ellison, chairman, presiding. Roll call showed the following present:

Councilors:

First District.....Not represented
Second District.....William C. Reed, Bloomington
Third District.....William H. Garner, New Albany
Fourth District.....George A. May, Madison
Fifth District.....A. M. Mitchell, Terre Haute
Sixth District.....W. U. Kennedy, New Castle
Seventh District.....Cyrus J. Clark, Indianapolis
Eighth District.....E. H. Clauser, Muncie
Ninth District.....Wemple Dodds, Crawfordsville
Tenth District.....William H. Howard, Hammond
Eleventh District.....Elton R. Clarke, Kokomo
Twelfth District.....Paul A. Garber, South Whitley
Thirteenth District.....Alfred Ellison, South Bend

Officers:

Augustus P. Hauss, New Albany, president.
Claude S. Black, Warren, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
Frank B. Ramsey, Indianapolis, editor, THE JOURNAL.
C. H. McCaskey, Indianapolis, chairman, Executive Committee.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, Indianapolis, executive secretary.
James A. Waggener, Indianapolis, field secretary.

Guests:

Karl R. Ruddell, Indianapolis, alternate delegate to A.M.A.
J. Neill Garber, Indianapolis, chairman, Committee on Centennial Arrangements.
J. William Wright, Indianapolis } co-chairmen,
Don E. Wood, Indianapolis } Legislative Committee.
Neal E. Baxter, Bloomington, chairman, Committee on Maternal and Child Health.
Cleon A. Nafe, chairman, Indiana A.M.A. Coordinating Committee.
On motion of Drs. May and Clauser, the minutes of the spring meeting of the Council, held at Indianapolis on April 10, 1949, were approved as printed in the May, 1949, issue of THE JOURNAL.

Reports of Councilors

Reports on spring district meetings, on the progress of the A.M.A. educational campaign, and various other activities, indicated that all district societies are functioning satisfactorily.

Reports of Officers

Dr. Hauss, president: "I have very little to report except progress. Our state medical association is on the ball and is definitely working harder than ever before. Most of our members are alert to their responsibilities. The committees have done an excellent job, and much credit is due to the county societies and the state committees for what has been accomplished this year. We are assured of a great centennial."

Dr. Black, president-elect: "It will soon be coming into my year and I am sure that I am going to need the help of every councilor and every member of this state association to make my term of office function properly. This year four district societies held meetings on the same day. Next year I would like to go to every district meeting, if there are no conflicting dates. Councilors should clear their district meeting date through the headquarters office. If you don't have conflicting dates, I am going to promise you that I am going to be there."

Dr. Weyerbacher, treasurer: "When you check over our report of a year ago and now, our financial condition will look very glowing. A year ago our total assets were \$67,000.00; this year, at the end of December, 1948, they were \$80,000.00. Ten thousand dollars of this \$13,000.00 increase in assets were invested in United States Savings bonds in 1948. Although we had this increase in assets in 1948, we must not overlook the fact that beginning with 1949 our expenses have increased greatly."

Dr. Ramsey, editor of THE JOURNAL, reported that THE JOURNAL is endeavoring to expand one activity, that is, the reprinting of editorials. "We would like to have a page or part of a page in THE JOURNAL each month which would reprint some of these editorials. If the councilors would watch their local papers and perhaps the Chicago, New York, Cincinnati and Louisville papers, particularly for editorials that might make good reading, both those on our side and those against us, and send these in to THE JOURNAL, we will publish them. This is on the suggestion of Dr. Cavins, with the idea that doctors don't have an opportunity to know what other people think of them. I think we can overcome that a little bit if we reprint some of these editorials."

"Another thing which we have under consideration and which we are going to discuss at the annual meeting of the Editorial Board is the suggestion of St. Elizabeth's Hospital in Lafayette that we publish a clinical pathological conference each month. If we do this we will have to do it pretty carefully. If it is done in the wrong way, it can become dull and uninteresting. St. Elizabeth's suggestion was that we not pick any particular hospital in the state, but that we take them in rotation. Let each hospital pick its most interesting and most publishable conference."

Dr. McCaskey, chairman, Executive Committee, presented the following matters:

(1) *Resolution introduced by Dr. Walter L. Portteus to the Executive Committee and referred by the Executive Committee to the Council for action:*

WHEREAS, the medical profession of the United States is engaged in a struggle for its very existence and it is requesting public support of the present system of medicine; and

WHEREAS, the profession is cognizant of the fact that to gain the support of the public in this effort we must maintain good public relations and fulfill our obligations of service to the satisfaction of the public that we may continue our freedom in the practice of medicine; and

WHEREAS, the misdeeds of a few of our profession receive widespread publicity, reflecting public disfavor upon the entire profession; and

WHEREAS, the public feels it has no recourse for its just complaints; and

WHEREAS, it is difficult for small units of our society to police the offenders;

NOW, THEREFORE BE IT RESOLVED, That a grievance committee be created by the House of Delegates, consisting of the five living immediate past presidents of the Indiana State Medical Association, which committee would review complaints both from within the profession and from the general public; that this committee be empowered to act in the interest of good medical ethics; and that the establishment of such a committee be given wide publicity and full support of the physicians.

Dr. McCaskey said that the Executive Committee feels that the psychological effect of the creation of this committee will result in better relationships between the general public and the profession as a whole.

On motion of Drs. Clark and Dodds, the Council accepted this resolution, and on motion of Drs. Mitchell and Clauser, it is to be referred to the House of Delegates.

(2) *Recommendation regarding change in term of office of president.* "Upon motion of Dr. Black and a second by Dr. Portteus, the Executive Committee voted to present to the Council the recommendation that the president of the Indiana State Medical Association assume office at the close of the annual state convention. Most other organizations use this system and it provides a way for some ceremony and permits the organization to begin the coming year's work immediately following the close of the convention. It is hoped that this will be presented to the House of Delegates."

Dr. Weyerbacher called attention to the fact that there are only two elective offices, president-elect and treasurer. He suggested that the treasurer be included in this recommendation.

On motion of Drs. Hauss and Clark this recommendation of the Executive Committee was adopted. Dr. Hauss' motion included the suggestion of Dr. Weyerbacher that the treasurer's term of office be the same as that of the president. On motion of Drs. Mitchell and Garber this recommendation is to be referred to the House of Delegates.

Unfinished Business

(1) *Nominations for Editorial Board.* Dr. Wemple Dodds, Crawfordsville (pathology) and Dr. Stephen L. Johnson, Evansville (internal medicine) were nominated at the midwinter meeting of the Council on January 16, 1949. Drs. Clark and Garber moved that the nominations be closed. Motion passed.

(2) *Matters to be referred to the House of Delegates.*

a. On motion of Drs. Clark and Mitchell, the recommendation made by the Council at the midwinter meeting on January 16, 1949, that Section 1, Chapter XII, of the By-laws be changed so that \$1.25, instead of 75c, will be taken from each member's dues for deposit in the medical defense fund, is to be presented to the House of Delegates by the chairman of the Council.

b. On motion of Drs. Clark and Mitchell, the chairman of the Council is to present to the House of Delegates the recommendation of the Council that membership dues in the Indiana State Medical Association be increased \$5.00, which would make the annual state association dues \$20.00 per year.

c. *Rebating.* The report of the A.M.A. Committee on Rebates, calling attention to the fact that the A.M.A. House of Delegates at its interim session in St. Louis in December, 1948, reiterated its "condemnation of the practice of any member accepting rebates, and that the House of Delegates condemns also the practice of giving rebates by a member," was referred by the Executive Committee to the Council, with the suggestion that the matter be referred to the Indiana State Medical Association House of Delegates. The report of the A.M.A. Committee on Rebates further stated, "The committee urges that the different state societies in those states in which such practices are not now illegal give serious consideration to the introduction of legislation making the practice of rebating to or by physicians illegal."

On motion of Drs. Hauss and Elton Clarke this recommendation of the A.M.A. was approved by the Council.

1949 (Centennial) Annual Session at Indianapolis

DR. J. NEILL GARBER, chairman of the Committee on Centennial Arrangements, reported on the satisfactory progress of the entertainment plans for the centennial session and that so far, expenses are going to be well within the budget allowed.

Membership Problems

(1) Report on 1949 membership showed an increase of 78 members over this time last year. It also was noted that 36 members are in military service whereas the quota for Indiana is 67. On motion of Drs. Clark, Black and Garber, the recommendation was made to the editor of THE JOURNAL "that some sort of stimuli be promulgated to encourage at least government-educated doctors to volunteer for a term of duty."

(2) *Certification of honorary members.* On motion of Drs. Garber and Mitchell, the Council accepted for honorary membership in the state association two members who recently have become eligible to this classification.

(3) *Union of Crawford County Medical Society with Harrison County Medical Society.* Dr. Garner reported that two members of the Crawford County Medical Society are going to join the Harrison County Medical Society and one other Crawford county physician is a member of the Orange County Medical Society. The new society will be the Harrison-Crawford County Medical Society if this reorganization takes place.

(4) *A.M.A. assessment.* On motion of Drs. C. J. Clark and Elton Clarke, the Council instructed the headquarters office to ask the county society secretaries to notify all of their members who have not yet remitted \$25.00 to cover the assessment levied by the A.M.A. against each member.

Legislative Matters

Dr. J. William Wright, co-chairman of the Committee on Public Policy and Legislation, spoke briefly on national legislation.

New Business

(1) *Mutual Medical Insurance, Inc.* Dr. Kennedy, chairman, gave a brief report on the present status of this company.

(2) *Public Relations.* Dr. Dodds, chairman, read the annual report which his committee is submitting to the House of Delegates, with some amplifications.

(3) *A.M.A. meeting, June 6-19, 1949, Atlantic City.* Dr. Mitchell, alternate delegate, gave a detailed report on the annual session of the A.M.A., held in Atlantic City in June.

(4) *St. Paul-Mercury Indemnity Company.* Attention of the Council was called to the fact that the St. Paul-Mercury Indemnity Company gives the physician an opportunity to select his own attorney and the company pays for that attorney, whether it be Mr. Stump or some other attorney. Other companies say that Mr. Stump is attorney for the state medical association and the association must pay his fee. The Executive Committee feels that the membership should be made aware of this and that the St. Paul-Mercury Indemnity Company should be encouraged to send out a statement to the membership outlining these facts. On motion of Drs. Mitchell and Clark the Council tabled this suggestion with the view that the procedure to be followed in this instance is a matter for the St. Paul-Mercury Indemnity Company to decide.

(5) *Payment of expenses of editor of THE JOURNAL to A.M.A. meetings.* On motion of Drs. Clark, Mitchell and Kennedy, the expenses of the editor of THE JOURNAL in attending A.M.A. meetings are to be paid on the same basis as those of delegates, that is, railroad fare, including Pullman, plus \$10.00 per diem.

(6) *Indiana A.M.A. Coordinating Committee.* Dr. Nafe, chairman, reported that the committee had distributed, on request, 413,399 pamphlets and pieces of literature to

date. "We have tried to stimulate speaking. We have arranged for distribution of material to drug stores, and we have secured the full cooperation of very many fine organizations, nearly all of which have passed formal resolutions against compulsory health insurance."

Dr. Nafe called attention to the fact that there are many bills in Congress that have a tendency to do the same things that the Wagner-Murray-Dingell bill would do, and warned that something tangible should be done about these bills. "This committee, together with the Committee on Public Policy and Legislation and other committees should make every effort to keep aware of these facts."

(7) *Convention Publicity.* On motion of Drs. Clark and Mitchell, the Council revised the motion adopted at its October 28, 1948, meeting to read that "only speeches that are to be released to the press need to be edited by the Executive Committee."

(8) *Assistant Treasurer.* On motion of Drs. Clark and Mitchell the Council is to recommend to the House of Delegates that the position of assistant treasurer be created.

(9) *Committee on Maternal and Child Health.* Dr. Neal E. Baxter, chairman, reported on the two meetings of his committee which have been held this year. "We find that the maternal mortality rate has gone down markedly and we do not have many problems in that field. We also find that the loss of prematures is still exceedingly high. The committee has studied this problem and it is our recommendation that a premature training center be established at the I. U. Medical Center for the training of personnel in various hospitals over the state. We have conferred with Drs. Van Nuys, Huber and Meiks and they are in full accord with the establishment of such a center. Perhaps you are aware of the fact that Chicago, Boston, and some of the larger medical centers have established such activity and in so doing they have reduced the mortality rate of premature children. With your approval we hope that such a center can be established at the University Center. Financing of it probably will come from various sources. There are certain funds at the State Board of Health available for that use. Various organizations throughout the state have offered funds. Such a training center would be supervised by medical school personnel under the Department of Pediatrics. It is our sincere wish that the Council at least approve our recommendation and that we can get this activity going."

Following discussion by Drs. Nafe and Jewett, on motion of Drs. Elton Clarke and May the Council went on record as being in favor of the establishment of this premature training center.

(10) *Collection of Woman's Auxiliary dues.* Dr. Black read a letter from Mrs. Truman Caylor, president of the Woman's Auxiliary, in which the executive committee of the Auxiliary asked that the Association consider the collection of \$1.00 national and \$1.00 state dues of Auxiliary members at the same time the annual dues of members of the Indiana State Medical Association are collected by the county society secretaries. On motion of Drs. Black and Hauss this matter received the approval of the Council and it is to be referred to the House of Delegates.

(11) *Committee on Medical Education and Hospitals.* Dr. Clauser, chairman, presented two matters from his committee:

1. Establishment of postgraduate courses, and
2. Admission of foreign students to the teaching facilities of Indiana.

Dr. Clauser read the following recommendations which were adopted by his committee at its meeting on July 13:

"That, 1. A program of postgraduate education should be a cooperative effort between the Indiana State Medical Association, Indiana University School of Medicine, the Indiana State Board of Health, and other interested agencies. That the State Association, through this committee, should take steps to correlate these activities.

"2. Several districts should be selected by the Council upon recommendation of this committee for extensive postgraduate courses of study.

"3. The mechanics of operation of these courses should be under the direction of our field secretary, with the support and help of the councilor district and associate county medical societies.

"4. A fee not to exceed twenty-five dollars (\$25.00) should be charged for the series of courses.

"5. Qualified instructors should be paid an honorarium, not to exceed fifty dollars (\$50.00) and expenses, for each day spent in participating in this program.

"6. Five thousand dollars (\$5,000.00) be appropriated for meeting the expenses of this program, hoping that the majority of this will be repaid by fees charged for these courses. The salary of the field secretary will not be charged against this account."

This was discussed by Drs. Nafe, Mitchell, Dodds, Clauser and Hauss.

DR. HAUSS: "I am definitely in favor of postgraduate education. I think that our state association should formulate and establish a plan. The recommendations and study of the committee are fine as far as they go, but I do believe that before these recommendations are presented to the House of Delegates, they should be in more concrete form and definitely specify what is to be expected from these postgraduate courses and how far-reaching they will be. The delegates will want to know that. As far as the Council is concerned, I move that we endorse the principles contained in the report of Dr. Clauser's committee and that a more specific report be given to the House of Delegates for its consideration." Motion seconded by Dr. Kennedy, and carried.

DR. CLAUSER: "The committee also discussed the problem of granting opportunity of postgraduate study in our teaching institutions, to foreign students, without the necessity of their procurement of license to practice medicine in Indiana. It was decided to refer the matter to the Council for their consideration." Dr. Clauser presented all the facts pertinent to this question, and added, "This matter needs serious consideration and it should be clarified." Discussion followed by Drs. Mitchell, Howard, Reed, McCaskey, Nafe and May. On motion of Drs. Mitchell and Garber, this portion of the report of the Committee on Medical Education and Hospitals was held over for further consideration at the next meeting of the Council.

There being no further business, the meeting was adjourned at 3:00 p.m.

EXECUTIVE COMMITTEE

July 30, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Porteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith and J. A. Waggener.

Guests: Lester D. Bibler, M.D., president, and Norman R. Booher, M.D., secretary-treasurer, Indiana Academy of General Practice.

Membership Report

Number of members July 26, 1949	3,693*
Number of members July 26, 1948	3,615
Gain over last year	78
Number of members Dec. 31, 1948	3,689

* Includes 36 in military service (gratis)

188 honorary members

Legislative Matters

National

On motion of Drs. Ellison and Black the report of the field secretary on his activities was accepted and he was commended for doing a fine job.

Local

(1) Report made by the executive secretary that the State Board of Health is planning a series of community health conferences to create sentiment for the state-aid bill for full-time health departments. On motion of Drs. Portteus and Ellison, the committee re-affirmed its support of the bill.

Statements of receipts and expenditures for June for the association and THE JOURNAL were approved.

1949 Annual Session, Indianapolis, September 26-29, 1949

Permanent convention badges. The question of purchase of permanent convention badges was postponed until the next meeting of the committee.

Portable announcement screen. On motion of Drs. Ellison and Black, the purchase of a portable screen for convention announcements was approved.

Personal liability insurance. On motion of Drs. Hauss and Portteus, the executive secretary was directed to procure a policy on personal liability insurance covering the 1949 state meeting.

Bronze plaque for past presidents. On motion of Drs. Ellison and Portteus it was voted to present a bronze plaque to future retiring presidents, and a committee composed of Drs. Weyerbacher, McCaskey and the executive secretary was empowered to select the design and text.

Award for 1949 general practitioner. Dr. Weyerbacher reported that a painting by V. J. Cariani, entitled, "Along the Valley Road," had been purchased for the 1949 general practitioner award.

Annual dinner. Dr. Charles N. Combs will handle the seating of ex-presidents and councilors and their wives. Mrs. Frank Gastineau is to have charge of the seating of the Auxiliary officers and the wives of those seated at the speakers' table.

On motion of Drs. Portteus and Ellison, the agreement with the Murat Temple was approved.

House of Delegates' meetings. The first and second meetings of the House of Delegates, with the exception of the luncheon on September 29, are to be open to the entire membership, and these facts are to be made known in the convention program.

Prepayment Medical Care Insurance

Letter from The Hoosier Casualty Company, addressed to the American Medical Association, setting forth the commercial insurance companies' view on socialized medicine was read by the field secretary.

Organization Matters

Training of technicians to do simple laboratory procedures. The president and secretary-treasurer of the Indiana Academy of General Practice presented arguments in favor of a short training course, and they were asked to suggest a proposed training course and present it at the next meeting of the Executive Committee.

On motion of Drs. Portteus and Hauss, a 1949-50 membership in the Hoosier State Press Association was approved.

On motion of Drs. Hauss and Portteus, a corporate membership in the Indiana Public Health Association for 1949-50 was approved.

The report of the A.M.A. Bureau of Medical Economic Research on revision of insurance examination fees was referred to Dr. Portteus on motion of Drs. Hauss and Black.

An editorial from the July 13, 1949, issue of *The Shelbyville News*, praising Shelby county physicians for their response when called to attend persons injured in a bad automobile accident, was read, and on motion of Drs. Hauss and Ellison the executive secretary was directed to write a letter of thanks to the editor and send a copy to the president of the Shelby County Medical Society.

A resolution proposing the creation of a grievance committee was approved and referred to the Council on motion of Drs. Black and Ellison.

Proposed conference with Executive Committee of the Indiana Pharmaceutical Association on subject of dispensing dangerous drugs. The committee agreed to this conference and set 2:45 p.m., Sunday, August 28, for the meeting, at the Columbia Club.

1950 A.M.A. meeting. On motion of Drs. Hauss and Portteus, the committee approved the sightseeing tour that has been proposed in connection with the A.M.A. meeting in San Francisco in June, 1950.

Suggested change in terms of association officers. The executive secretary read a letter which he had sent to the chairman of the Committee on Constitution and By-Laws suggesting that association officers serve from convention to convention instead of from January 1 to January 1. The suggestion was approved on motion of Drs. Black and Portteus and it was to be referred to the Council.

The Journal

Report on advertising:

Increases to July 30, 1949-----\$ 386.25
No decreases-----

Total increase for month-----\$ 386.25

Total increase for year-----\$3,486.35

The request of the Central Laboratories, Indianapolis, for advertising space was denied on motion of Drs. Ellison and Portteus.

There being no further business, the committee adjourned to meet again at 10:00 a.m., Sunday, August 28, at the Columbia Club.

COMMITTEE ON PUBLICITY

July 1, 1949

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and J. A. Waggner, field secretary.

The following "Hints on Health" column was approved:

Week of August 15, 1949—"Watch the Heat."

The secretary read an article for release to the general press, telling of the activities of the various county medical societies in solving the problem of providing twenty-four hour per day medical service. The article was based on the survey of the county societies by the Publicity Committee. The article was approved for release.

An article entitled, "Uncle Sam May Pay Doctor Bills, but He Will Use Your Tax Money," prepared by the executive secretary for use in papers desiring a summarization of the articles explaining the proposed compulsory health insurance legislation, which were written by Wray Fleming of the Hoosier State Press Association, was read and approved for use.

The committee selected the new radio series entitled "The Story Behind the Discovery," for use on station WFBM beginning with the program on Saturday, August 13, 1949.

July 15, 1949

Meeting called to order at 4:15 p.m.

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Ray E. Smith, executive secretary, and J. A. Waggner, field secretary.

The following "Hints on Health" columns were approved:

Week of August 22, 1949—"Century of Progress."

Week of August 29, 1949—"Physical Therapy."

The secretary told of a request received from the Council of Women for a speaker on November 1, 1949, to discuss the subject of "Health Through Understanding." Dr. Don E. Wood of Indianapolis was selected to speak and was asked to emphasize preventive medicine.

The annual report of the committee to the House of Delegates was approved.

ONE-HUNDRETH

Annual Session

INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana

September 26, 27, 28 and 29, 1949

Headquarters — Murat Temple

Complete Program on following pages



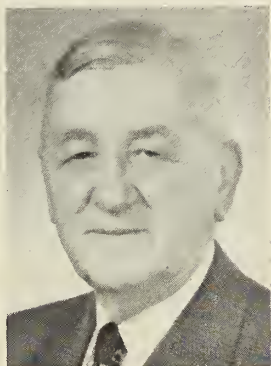
AUGUSTUS P. HAUSS, M.D

New Albany

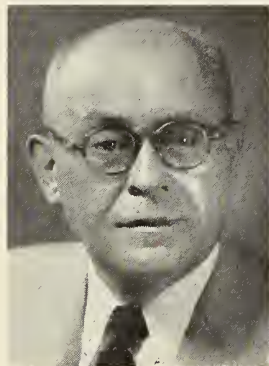
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INDIANA STATE MEDICAL ASSOCIATION
1949

INDIANA STATE MEDICAL ASSOCIATION

Officers - 1949



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State Medical Association
Bluffton



E. M. SHANKLIN
Editor Emeritus
THE JOURNAL
Hammond



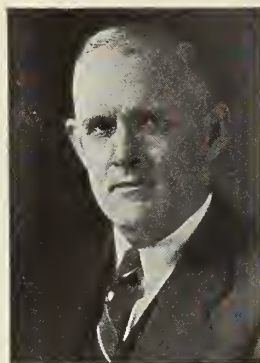
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Editor
THE JOURNAL
Indianapolis



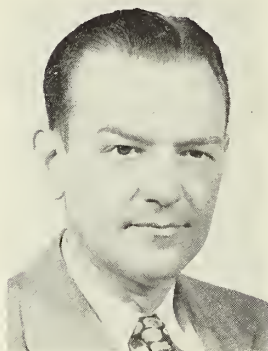
A. W. CAVINS
Associate Editor
THE JOURNAL
Terre Haute



ALFRED ELLISON
Chairman of Council
South Bend



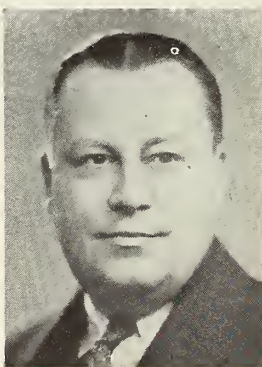
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Indianapolis



J. NEIL GARBER
Chairman
Convention Arrangements
Indianapolis



W. L. PORTEUS
Executive Committee
Franklin



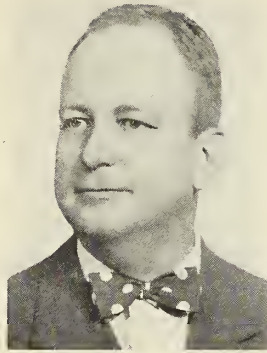
RAY E. SMITH
Executive Secretary and
Managing Editor of
THE JOURNAL
Indianapolis



J. A. WAGGENER
Field Secretary
Indianapolis



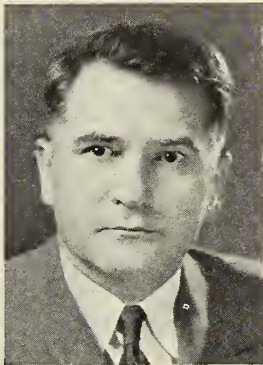
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Section on Medicine
Evansville



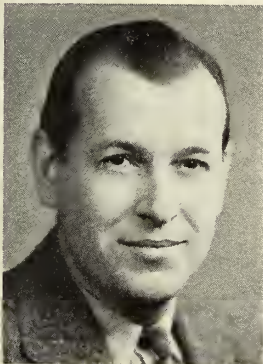
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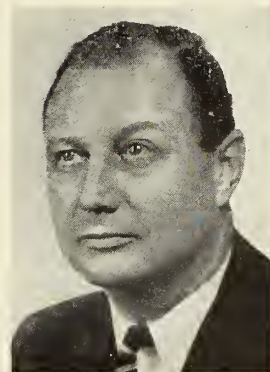
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Section on Surgery
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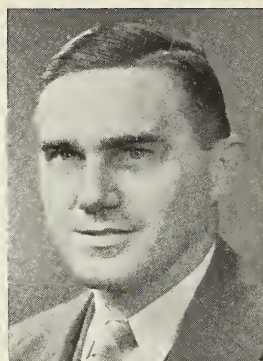
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and Otolaryngology
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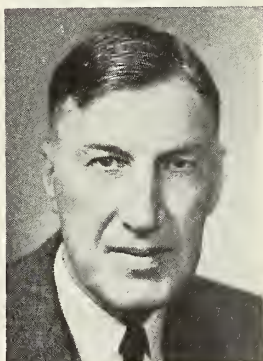
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RICHARD E. EDMONDSON
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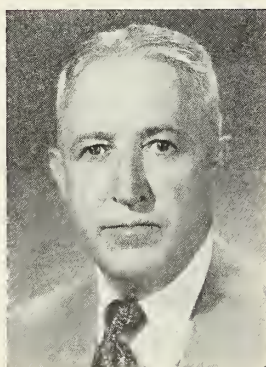
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Editorial Board
Gary

Official Program

One-hundredth Annual Session
INDIANA STATE MEDICAL ASSOCIATION

Murat Temple
Indianapolis, Indiana

September 26, 27, 28 and 29, 1949

Monday, September 26, 1949

Morning

- 8:00 a.m. Registration starts, lounge room, Murat Temple.
- 10:00 a.m. Opening of technical exhibit, lounge room, Murat Temple.
Scientific and historical exhibits, Egyptian Room, Murat Temple.
- 10:00 a.m. Council meeting, Kneipe Room, Murat Temple. Luncheon at 12:30 p.m.
- 10:00 a.m. Annual trap and skeet shoot, Indiana Gun Club.
- 10:30 a.m. Annual golf tournament. Medal play, based on low gross and handicap. Highland Golf and Country Club.
- 11:00 a.m. Instructional courses, Dining Room, Murat Temple.

Afternoon

- 1 to 5 p.m. Instructional courses, Dining Room, Murat Temple.
- 1:30 p.m. Editorial Board meeting, Officers' Room, Murat Temple.
- 3:00 p.m. Meeting of House of Delegates, Murat Theater. (All association members are welcome.)

Evening

- 6:30 p.m. Annual dinner meeting for women physicians, Parlor A, Indianapolis Athletic Club.
- 7:00 p.m. Buffet supper, smoker and stag party, Dining Room, Murat Temple.

Tuesday, September 27, 1949

Morning

- 7:30 a.m. Breakfast meeting of Committee on Industrial Health, Club Room I, Hotel Lincoln.
- 8:00 a.m. Registration continues, lounge room, Murat Temple.
- 8:30 a.m. Technical exhibit, lounge room, Murat Temple.
Scientific and historical exhibits, Egyptian Room, Murat Temple.
- 9 a.m. to 12 m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Company.)

GENERAL MEETING

MURAT THEATER

- 9:30 a.m. Call to order by Augustus P. Hauss, M.D., New Albany, president, Indiana State Medical Association.
- 9:30 a.m. Greetings by Willis D. Gatch, M.D., Indianapolis, president of Indianapolis Medical Society, and J. Neill Garber, M.D., Indianapolis, chairman of Committee on Centennial Arrangements.
- 9:35 a.m.



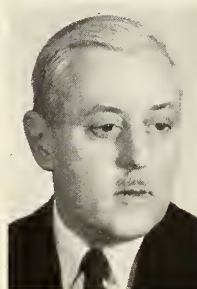
DAVID A. BICKEL,
M.D., South Bend.

and



CARL S. CULBERTSON, M.D., South Bend.

Subject: "*Intra-epithelial Carcinoma of the Cervix.*"



CARL P. HUBER, M.D., Chairman, and Professor of Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis.
Subject: "*The Safety of Cesarean Section.*"

(Tuesday, September 27, 1949)

- 10:15 a.m. President's address, AUGUSTUS P. HAUSS, M.D., New Albany.
 10:40 a.m. Ten-minute intermission.
 10:50 a.m.



EDWARD G. BILLINGS, M.D., Associate Professor of Psychiatry, University of Colorado School of Medicine, Denver.
 Subject: "The General Principles of Psychotherapy in General Practice."

11:15 a.m.

ROLLAND J. WHITACRE, M.D., East Cleveland, Ohio.
 Subject: "Prevention Preferred in the Operating Room."



- 11:40 a.m. Time allowed to view scientific, technical and historical exhibits.

SECTION MEETINGS

- 11:40 a.m. Meeting of Section on Obstetrics and Gynecology, Officers' Room, Murat Temple. Election of section officers for 1950.
 11:45 a.m. Meeting of Section on General Practice, Murat Theater. Election of section officers for 1950.
 11:45 a.m. Meeting of Section on Medicine, Dining Room, Murat Temple. Election of section officers for 1950.

Noon

- 12m. Nu Sigma Nu luncheon meeting, Blue Room, Athenaeum.
 12m. Phi Beta Pi luncheon meeting, East Room, Athenaeum.
 12m. Phi Rho Sigma luncheon meeting, Kneipe Room, Murat Temple.
 12m. Luncheon meeting of Committee on Maternal and Child Health, Columbia Club.

SECTION MEETING

- 12:15 p.m. Luncheon meeting of Section on Anesthesia, Directors' Room, Athenaeum.
 Speaker: ROLLAND J. WHITACRE, M.D., East Cleveland, Ohio.
 Subject: "Postspinal Headaches."
 12:30 p.m. Luncheon meeting, Indiana Roentgen Society, Fraternity Room, Athenaeum.
 Speaker: BYRL R. KIRKLIN, M.D., Professor of Radiology, University of Minnesota Graduate School, Minneapolis-Rochester.

(Tuesday, September 27, 1949)

Subject: "Remarks Concerning the American Board of Radiology."

Afternoon

- 1:30 to
 4:00 p.m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Co.)

GENERAL MEETING

MURAT THEATER

2:30 p.m.

RALPH J. McQUISTON, M.D., Indianapolis.
 Subject: "The Present Status of the Fenestration Operation in the Treatment of Deafness Due to Otosclerosis."



2:50 p.m.



BYRL R. KIRKLIN, M.D., Professor of Radiology, University of Minnesota Graduate School, Minneapolis-Rochester.
 Subject: "Bezoars of the Gastro-Intestinal Tract."

3:15 p.m.

WILLIAM THOMAS GREEN, M.D., Chairman, and Professor of Orthopedic Surgery, Harvard Medical School, Boston.
 Subject: "Practical Considerations in the Treatment of Poliomyelitis."



3:40 p.m. Ten-minute intermission.

3:50 p.m.



LEONARD A. SCHEELE, M.D., Surgeon General, United States Public Health Service, Washington, D.C.
 Subject: "The Physician's Role in the Fight Against Cancer."

(Tuesday, September 27, 1949)

4:15 p.m.



FRANK C. MANN, M.D., Professor of Experimental Medicine, Mayo Foundation for Medical Education and Research, University of Minnesota Graduate School, Rochester, Minn.
Subject: "*Hepatic Components in Some Physiological Processes.*"

9:30 a.m.

4:40 p.m.

UDO J. WILE, M.D., Professor Emeritus, Department of Dermatology and Syphilology, University of Michigan, Ann Arbor.
Subject: "*The Evaluation of Syphilis Therapy.*"



9:50 a.m.

5:05 p.m. Time allowed to view scientific, technical and historical exhibits.

Evening

8:15 p.m. Baltimore and Ohio Glee Club, Murat Theater. (Program will start promptly at 8:15 p.m. because of broadcast at 8:30 p.m.)

Wednesday, September 28, 1949 Morning

7:30 a.m. Breakfast meeting of Committee on Conference of County Medical Society Officers, Hotel Lincoln.

7:30 a.m. Breakfast meeting of Committee on Mental Health, Parlor D, Indianapolis Athletic Club.

7:30 a.m. Breakfast meeting of members of the State and County Conservation of Vision Committees, Parlor A, Indianapolis Athletic Club.

Speaker: WILLIAM L. BENEDICT, M.D., Professor of Ophthalmology, University of Minnesota Graduate School, Minneapolis-Rochester.

9 a.m. to

12 m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Co.)

(Wednesday, September 28, 1949)

GENERAL MEETING

MURAT THEATER

ARTHUR N. FERGUSON, M.D., Fort Wayne.
Subject: "*Medical Treatment of the Bleeding Duodenal Ulcer.*"



HAROLD D. CAYLOR, M.D., Bluffton.
Subject: "*Surgical Treatment of the Bleeding Duodenal Ulcer.*"



10:10 a.m.

WILLIAM L. BENEDICT, M.D., Professor of Ophthalmology, University of Minnesota Graduate School, Minneapolis-Rochester.
Subject: "*The Significance of Ocular Vascular Accidents.*"



10:35 a.m. Ten-minute intermission.

10:45 a.m.



LOUIS G. HERRMANN, M.D., Associate Professor of Surgery, University of Cincinnati College of Medicine, Cincinnati.
Subject: "*Surgery of the Large Arteries.*"

(Wednesday, September 28, 1949)

11:10 a.m.

ARLIE R. BARNES, M.D., Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota, and head of a section of the division of medicine of the Mayo Clinic, Rochester.

Subject: "The Effect of a Hormone of the Adrenal Cortex (17-hydroxy - 11 - dehydrocorticosterone: compound E) and of Pituitary Adrenocorticotrophic Hormone on Rheumatic Fever and Rheumatic Carditis."

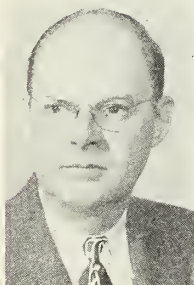


11:35 a.m. Time allowed to view scientific, technical and historical exhibits.

Noon

12 m. Indiana Academy of General Practice luncheon, Kellersaal Room, Athenaeum.

Speaker: RUFUS B. ROBINS, M.D., Professor of Medical Economics, University of Arkansas School of Medicine, and member of A.M.A. Coordinating Committee for the Protection of the People's Health, Camden, Arkansas.
Subject: "The Doctor as a Citizen."



12:30 p.m. Luncheon and business meeting, Indiana Association of Pathologists, Empire Room, Claypool Hotel.

Afternoon

1:30 to

4:00 p.m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Co.)

GENERAL MEETING

MURAT THEATER

2:30 p.m.



MAX D. GARBES, M.D., Instructor in Pediatrics, The University of Rochester School of Medicine and Dentistry, Rochester, N. Y.
Subject: "Newer Antibiotics in the Treatment of Diseases of Children."

2:55 p.m.

(Wednesday, September 28, 1949)



S. R. SNODGRASS, M.D., Associate Professor of Neurosurgery, University of Texas School of Medicine, Galveston, Texas.

Subject: "Early Diagnosis of Intracranial Tumor."

3:20 p.m. Ten-minute intermission.

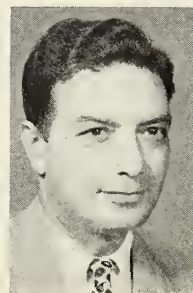
3:30 p.m. Panel on "Peripheral Vascular Diseases."
Moderator: ARLIE R. BARNES, M.D., Rochester, Minn.

Discussion: WILLIAM L. BENEDICT, M.D., Rochester, Minn.

CHARLES A. HUFNAGEL, M.D., Harvard Medical School, Boston.



LOUIS G. HERRMANN, M.D., Associate Professor of Surgery, University of Cincinnati, College of Medicine, Cincinnati.



HARRIS B. SHUMACKER, M.D., Professor of Surgery, Indiana University School of Medicine, Indianapolis.

4:50 p.m. Time allowed to view scientific, technical and historical exhibits.

SECTION MEETING

5:00 p.m. Meeting of Section on Ophthalmology and Otolaryngology, Officers' Room, Murat Temple. Election of section officers for 1950.

(Wednesday, September 28, 1949)

Evening

- 5:30 p.m. Dinner meeting and reunion of class of 1909 of Indiana University School of Medicine, Directors' Room, Athenaeum. 40th anniversary.
- 6:00 p.m. Dinner meeting and reunion of class of 1937 of Indiana University School of Medicine, Athenaeum.
- 8:15 p.m. Meeting for members, their wives and guests, Murat Theater. Musical program.

Speaker: WILTON MARION KROGMAN, Ph.D., Professor of Physical Anthropology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Subject: "The Bones Speak of Murder."

**Thursday, September 29, 1949****Morning**

- 9 a.m. to 12 m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Co.)

GENERAL MEETING**MURAT THEATER**

- 9:30 a.m. Clinicopathological Conference.



Moderator: WEMPLE DODDS, M.D., Crawfordsville.

Discussion: LALL G. MONTGOMERY, M.D., Muncie, and DAVID ADLER, M.D., Columbus.



(Thursday, September 29, 1949)

- 10:30 a.m. Ten-minute intermission.
- 10:40 a.m.



DONALD A. COVALT, M.D., Associate Professor of Rehabilitation, New York University College of Medicine, New York.

Subject: "Dynamic Therapy in Chronic Disease."

11:05 a.m.

HOWARD C. COGGESHALL, M.D., Assistant Professor of Clinical Medicine, Southwestern Medical College, Dallas, Texas.

Subject: "Treatment of Arthritis."



- 11:00 a.m. Final meeting of House of Delegates, Auditorium, Athenaeum. Luncheon at 12:30 p.m., East Room, Athenaeum. (All members welcome to meeting in Auditorium. Luncheon for delegates only.) Meeting of Council immediately following adjournment of House of Delegates.
- 11:30 a.m. Time allowed to view scientific, technical and historical exhibits.

SECTION MEETING

- 11:45 a.m. Meeting of Section on Surgery, Murat Theater. Election of section officers for 1950.

Noon

- 12 m. U. S. Naval Reserve Medical Officers Luncheon, Directors' Room, Athenaeum.
- 12 m. Luncheon meeting of members of State and County Tuberculosis Committees, Kneipe Room, Murat Temple. Indiana Chapter of American College of Chest Physicians participating.
- Speakers: MERLE BUNDY, M.D., director, Division of Tuberculosis Control, Indiana State Board of Health, Indianapolis.
- Subject: "What Procedures Shall Be Used for the Tuberculosis Follow-up of Children Under Fifteen Years of Age?"
- HUBERT B. PIRKLE, M.D., Rockville.
- Subject: "Results of P.A.S. Treatment in a Series of Cases."
- X-ray Conference.

(Thursday, September 29, 1949)

Afternoon

1:30 to

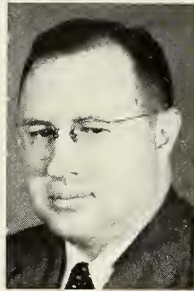
4:00 p.m. Television program, Candidates' Room, Murat Temple. (Through courtesy of Eli Lilly & Co.)

GENERAL MEETING

MURAT THEATER

2:30 p.m. Panel discussion: "Hospital Rules and Regulations."

Moderator: JOHN D. VAN NUYS, M.D., Indianapolis.



Discussion: E. H. CLAUSER, M.D., Muncie.

MARTHA O'MALLEY, M.D., Indianapolis.



ALBERT STUMP, Indianapolis. (Legal aspects.)

3:15 p.m. Ten-minute intermission.

3:25 p.m.

JAMES F. BALCH, M.D., Indianapolis.
Subject: "Urinary Antiseptics."



(Thursday, September 29, 1949)

3:45 p.m. Symposium on "Modern Management of Thyroid Diseases."

Moderator: JAMES O. RITCHEY, M.D., Indianapolis.

1. "The Classification and Differential Diagnosis," STEPHEN L. JOHNSON, M.D., Evansville.



2. "The Use of Propyl-thiouracil and Radio-active Iodine," DONALD J. WOLFRAM, M.D., Indianapolis.

3. "The Surgical Treatment of Hyperthyroidism," KARL M. KOONS, M.D., Indianapolis.



4. "The Treatment of the Thyrocardiac with an Evaluation of Present-Day Anti-thyroid Drugs," JAMES O. RITCHEY, M.D., Indianapolis.

4:45 p.m. Adjournment.

(Thursday, September 29, 1949)

Evening

6:30 p.m. Annual dinner and dance, Indiana Ballroom.

Presiding officer, AUGUSTUS P. HAUSS, M.D., president, Indiana State Medical Association.

Presentation of award to CLEON A. NAFE, M.D., president 1948, by Augustus P. Hauss, M.D.

Recognition of Fifty-Year Club members.
Award to General Practitioner of the Year.

Speaker: KENNETH McFARLAND, Superintendent of Schools, Topeka, Kansas.
Subject: "Behold This Day."



Women's Entertainment

Monday, September 26, 1949

8:00 a.m. Registration starts, lounge room, Murat Temple.

7:00 p.m. Dinner, honoring past presidents of Woman's Auxiliary to the Indiana State Medical Association, Indianapolis Athletic Club.



Speaker: EMILY KIMBROUGH.

Music by Purdue University entertainers.

1:00 p.m. Luncheon, Indianapolis Athletic Club.



Speaker: MARY MCGINN, of Whitaker and Baxter.

Fashion show, through courtesy of William H. Block Company.

8:15 p.m. Concert, Baltimore and Ohio Glee Club, Murat Theater. (Program will start promptly at 8:15 p.m. because of broadcast at 8:30 p.m.)

Tuesday, September 27, 1949

8:00 a.m. Registration continues, lounge room, Murat Temple.

9:30 a.m. Board meeting. Woman's Auxiliary to the Indiana State Medical Association, Green Room, Indianapolis Athletic Club.

11:30 a.m. Round table discussion, Green Room, Indianapolis Athletic Club, led by the chairmen of—

1. Legislation.
2. Public Relations.
3. Hygeia.
4. Program.
5. Organization.
6. Radio.
7. Parliamentary Law.

Wednesday, September 28, 1949

8:00 a.m. Registration continues, lounge room, Murat Temple.

12 m. to 4:00 p.m. Tour and luncheon at Eli Lilly and Company. Busses will leave from Murat Temple.

8:15 p.m. Meeting in conjunction with the Indiana State Medical Association, Murat Theater. Musical program and speaker.

Thursday, September 29, 1949

8:00 a.m. Registration continues, lounge room, Murat Temple.

3 to 5 p.m. Garden party, Governor's Mansion.

6:30 p.m. Annual dinner and dance in conjunction with the Indiana State Medical Association, Indiana Ballroom.

CONVENTION PROGRAM OFFERS TOPNOTCH ENTERTAINMENT

PHYSICIANS and their wives attending the 100th birthday party of the Indiana State Medical Association at Indianapolis, September 26 through September 29, will enjoy grade A entertainment. The committees have arranged something outstanding for each of the four nights.

While the doctors enjoy themselves at their annual buffet supper and stag party at the Murat Temple, Monday night, September 26, their wives and the women physicians will dine at the Indianapolis Athletic Club and will be entertained by a student group from Purdue University. The feature of the program will be a humorous talk by Muncie-born Emily Kimbrough, magazine editor, authoress and lecturer. This dinner is for all women and not just auxiliary members.

All physician's wives . . . not just auxiliary members . . . are invited to a luncheon at the Indianapolis Athletic Club Tuesday, September 27. Miss Mary McGinn, who is in charge of women's activities for Whitaker & Baxter, A.M.A. public relations counsel, will be the speaker, and Block's will present a fashion show.

The Murat theater will be the scene of the entertainment on Tuesday night, September 27, with "An Evening of Music," featuring the nationally-known Baltimore and Ohio Glee Club of

Baltimore, Maryland. This group of sixty male voices won the 1934 Chicago Musicland Male Chorus Contest and placed second in the 1948 contest. It has been heard over national radio chains many times. The association is fortunate in getting this famous singing organization. Roy Barton White, president of the railroad, began his railroad career at Dana, Indiana, and lived in the state for fifteen years. It was only because of his attachment for Indiana that the committee was able to get the glee club to participate in the centennial program. Thirty minutes of the concert is to be broadcast over a fourteen-station Indiana network.

The program Wednesday night in the theater will be entirely different, but equally as good. Dr. Wilton M. Krogman of Philadelphia, renowned anthropologist, will present his interesting and humorous lecture, "The Bones Speak of Murder." He will give amusing details of crime detective work. Persons who have heard him are saying "Don't miss hearing Doctor Krogman!" The colorful and beautiful vocal ensemble, "The Singing Marines," featuring Miss Dorothea Day, prima donna of the Chicago Civic Opera; Eddy Kozak, outstanding marimba stylist, and Tommy Moriarty and his orchestra, will complete the program.



THEY CAN SING AS WELL AS RUN A GOOD RAILROAD

The famous Baltimore and Ohio Glee Club Will Entertain You Tuesday Night, September 27, 1949

The wives of doctors will be guests of Mrs. Henry F. Schricker, First Lady of Indiana, at a Garden Party at the Governor's Mansion, from 3 o'clock to 5 o'clock, Thursday afternoon, September 29. The Executive Mansion will be open for those who wish to go through it. Mrs. Schricker, incidentally, is the daughter of a physician.

The annual dinner at the Indiana Ballroom on Thursday night, September 29, will be a triple-feature event and a grand finale to the centennial celebration. Reservations are limited, and the wise will buy tickets early. The program proper will include presentation of the past president's award to Dr. Cleon A. Nafe of Indianapolis; presentation of the award to the "General Practitioner of the Year"; recognition of physicians who have practiced for fifty years; special birthday features; and an address by Dr. Kenneth McFarland, superintendent of schools at Topeka, Kansas, a brilliant orator.

The dinner program will be different from any ever presented by the association. Miss Kay Keiser,

theatrical producer, has procured Jimmy James and his orchestra, currently featured over WLW, Cincinnati, to play for dancing. The Mid-States Four, vocal harmony specialists and international quartet champions, and the Kaydettes, instrumental strollers, will entertain in the early evening.

During the Centennial Ball, starting at 10 o'clock, a star-studded floor show will be presented. It will feature such night club stars as "Woo Woo" Stevens and his banjo, and the famous Dorothy Dorben Dancers of Chicago, also known as the Chez Paree Adorables.

The committee has announced that a \$500 combination RCA radio and television set will be given away during the evening as a door prize. The merrymaking will last until 1 a.m.

The Tuesday and Wednesday night entertainments are open to all members of the association and their families without admission charge. Tickets for the Centennial Dinner and Ball will be \$5 each.



I n d i a n a B a l l r o o m ,
scene of the Centennial
Banquet and Ball on
Thursday night, Sep-
tember 29, 1949. Here
the big 100th anniver-
sary party of I.S.M.A.
will end, to the tinkling
tunes of Jimmy James
and his orchestra.

STAG PARTY

A buffet supper, smoker and stag party is scheduled for 7:00 p.m., Monday, September 26, in the Egyptian Room, Murat Temple.

NU SIGMA NU LUNCHEON MEETING

Nu Sigma Nu will hold a luncheon meeting on Tuesday, September 27, at 12 m. in the Blue Room at the Athenaeum.

PHI BETA PI LUNCHEON MEETING

Phi Beta Pi will have a luncheon meeting at 12 m. on Tuesday, September 27, in the East Room of the Athenaeum.

SECTION ON ANESTHESIA LUNCHEON

A luncheon meeting of the Section on Anesthesia will be held at 12:15 p.m., Tuesday, September 27, in the Directors' Room at the Athenaeum. Rolland J. Whitacre, M.D., East Cleveland, Ohio, will speak on "Postspinal Headaches." Advance reservations must be made through Richard E. Edmondson, M.D., 2201 S. Center Street, Terre Haute, as there will be room for only fifty.

PHI RHO SIGMA ALUMNI LUNCHEON

The Phi Rho Sigma Alumni Association will have a luncheon meeting in the Kneipe Room, Murat Temple, on Tuesday, September 27, at 12 m.

MUSICAL PROGRAM FOR MEN AND WOMEN

The Baltimore and Ohio Glee Club will be presented in a musical program for men and women in the Murat Theatre, on Tuesday, September 27, at 8:15 p.m.

COUNTY MEDICAL SOCIETY OFFICERS BREAKFAST MEETING

A breakfast meeting of the Committee on Conference of County Medical Society Officers will be held at the Hotel Lincoln, at 7:30 a.m., on Wednesday, September 28.

CONSERVATION OF VISION COMMITTEES BREAKFAST

There will be a breakfast meeting for members of the State and County Conservation of Vision Committees on Wednesday, September 28, at 7:30 a.m., in Parlor A, Indianapolis Athletic Club. William L. Benedict, M.D., Rochester, will be the speaker.

INDIANA ACADEMY OF GENERAL PRACTICE LUNCHEON

A luncheon for members of the Indiana Academy of General Practice will be held on Wednesday, September 28, in the Kellersaal Room of the Athenaeum at 12 m. Rufus B. Robins, M.D., University of Arkansas School of Medicine, will speak on "The Doctor as a Citizen."

EDITORIAL BOARD MEETING

A meeting of the Editorial Board of THE JOURNAL of the Indiana State Medical Association will be held in the Officers' Room, Murat Temple, at 1:30 p.m., Monday, September 26.

DINNER FOR WOMEN PHYSICIANS

The annual dinner meeting for women physicians will be held at the Athenaeum at 6:30 p.m. on Monday, September 26.

INDIANA ASSOCIATION OF PATHOLOGISTS LUNCHEON

At 12:30 p.m., on Wednesday, September 28, there will be a luncheon and business meeting of the Indiana Association of Pathologists in the Empire Room of the Claypool Hotel.

1937 CLASS REUNION

A dinner meeting and reunion of the class of 1937 of the Indiana University School of Medicine will be held on Wednesday, September 28, at 6:00 p.m. at the Athenaeum.

1909 CLASS REUNION

There will be a 40th anniversary dinner meeting and reunion of the class of 1909 of the Indiana University School of Medicine at 5:30 p.m. on Wednesday, September 28, in the Directors' Room, Athenaeum.

"THE BONES SPEAK OF MURDER"

Wilton Marion Krogman, Ph.D., Philadelphia, will speak on "The Bones Speak of Murder" at a meeting and musical program for members of the association, their wives and guests on Wednesday, September 28, at 8:15 p.m., in the Murat Theatre. Don't miss it!

U. S. NAVAL RESERVE OFFICERS LUNCHEON

On Thursday, September 29, at 12:00 m., the U.S. Naval Reserve Officers will have a luncheon in the Directors' Room of the Athenaeum.

TUBERCULOSIS COMMITTEES LUNCHEON

Members of the State and County Tuberculosis Committees will hold a luncheon meeting at 12 m., on Thursday, September 29, in the Kneipe Room, Murat Temple, at which the Indiana Chapter of American College of Chest Physicians will participate. Speakers will be Merle Bundy, M.D., Indianapolis, and Hubert B. Pirkle, M.D., Rockville.

ANNUAL TRAP SHOOT

The annual Trap Shoot will be held at 10:00 a.m. on Monday, September 26, at the Indiana Gun Club, 38th Street and Post Road. One hundred target event. Shells and food are available at the Gun Club.

NEED A HOTEL RESERVATION FOR THE STATE MEETING?

(Indianapolis, September 26-29, 1949)

Start Calling Doctor Gillespie!

Don't stay at home because you haven't a hotel room for the I.S.M.A. convention—Dr. Jacob E. Gillespie and his Housing Committee will get you a room.

Write to Doctor Gillespie . . . not to a hotel . . . if you need a room. Use form below.

FOUR BIG DAYS AND NIGHTS!

Monday, September 26—Stag party for men and dinner party for all doctors' wives.

Tuesday, September 27—Concert by famous Baltimore & Ohio Railroad Glee Club.

Wednesday, September 28—Musical program and speech on crime, "The Bones Speak of Murder."

Thursday, September 29—Centennial banquet, dance and floor show. Music by Jimmy James and his orchestra. **THE BIG NIGHT!**

Scientific Lectures and Television Tuesday, Wednesday and Thursday

Hotels	Rates
Antlers	\$3.75- \$8.50
Barnes	\$2.00- \$6.00
Barton	\$2.25- \$7.00
Claypool	\$4.00-\$10.00
Graylynn	\$4.00- \$6.00
Harrison	\$3.25- \$8.75
Lincoln	\$3.50-\$10.00
Linden	\$2.00- \$6.00
Marott	\$4.50-\$10.00
Pennsylvania	\$2.75- \$5.00
Riley	\$2.25- \$6.00
Severin	\$3.50-\$10.00
Sheffield	\$3.50- \$7.00
Spencer	\$2.50- \$6.00
Spink-Arms	\$3.00-\$12.00
Stratford	\$2.00- \$6.00
Warren	\$3.50- \$8.50
Washington	\$3.25- \$8.50
Williams	\$2.25- \$6.00
York	\$2.00- \$5.00

HOTEL RESERVATION BLANK

Clip and Mail this coupon to Dr. Jacob E. Gillespie, 1201 Roosevelt Bldg., Indianapolis 4, Ind.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Indiana State Medical Association, September 26, 27, 28 and 29, or for such other period as may be indicated herein.

☐ Single Room with bath

☐ Double Room with bath

Price:.....

☐ Twin Bed Room with bath

☐ Suite

Arrival dateA. M.P. M.

Departure dateA. M.P. M.

Hotel Choices

Name

First

Address

Second

.....

Third

.....

Fourth

ORDER YOUR TICKETS FOR THE 1949 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1949 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Monday, September 26, 1949.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is \$1.00 per class with a maximum charge of \$3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now! Classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE

All Classrooms in Dining Room—On the Ground Floor						
Hour	Room A	Room B	Room C	Room D	Room E	Room F
11:00 A.M.	The Psychological Management of Patients Course 1	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 2	Ano-Rectal Conditions Course 3	Management of Common Gynecological Problems Course 4	Arthritis Course 5	Recent Developments in Antibiotic Therapy Course 6
NOON RECESS						
1:00 P.M.	Bedside and Office Diagnosis of Cardiac and Vascular Problems Course 7	The Management of Diabetes Mellitus Course 8	Diagnosis and Treatment of Common Skin Diseases Course 9	Infant Feeding Problems Course 10	The Problem of Obesity Course 11	Ear, Nose and Throat Emergencies Course 12
2:00 P.M.	The Demonstration of a Physical Diagnostic Examination Course 13	The Problems of Hypertension Course 14	Diagnosis and Treatment of Genito-Urinary Conditions in General Practice Course 15	Pediatrics in General Practice Course 16	The General Practitioner and Backache Course 17	Asthma, Hay Fever and Allergies in General Course 18
3:00 P.M.	Headache Course 19	The Management of the Menopause Syndrome Course 20	The Selection of Patients for Thoracic Surgery Course 21	Obstetrical Emergencies Course 22	Orthopedic Measures General Practitioners Can Use Course 23	What Can Neurological and Neurosurgical Treatment Offer Your Patient Course 24
4:00 P.M.	The Demonstration of a Diagnostic Neurological Examination Course 25	The Management of the Problems of the Elderly Course 26	The Management of Gastroenterology in General Practice Course 27	Impotence, Infertility and Maternal Health Service Course 28	A Lawyer Looks at Malpractice Suits Course 29	Diagnosis and Treatment of Common Skin Diseases Course 30

Cut on Dotted Line

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for \$1.00; \$2.00; \$3.00. Please reserve tickets for the following Instructional Courses:

First choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:
Second choice.....	11:00 A.M. No.:	1:00 P.M. No.:	2:00 P.M. No.:	3:00 P.M. No.:	4:00 P.M. No.:

(Insert course numbers plainly, please.)

I will pick up my tickets at the Registration Desk, September 26, 1949.

Signed:M.D.

Address:

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at Indianapolis, September 26, 27, 28, and 29, 1949.

The House of Delegates will be constituted as follows: Marion County, seventeen delegates; Lake County, six delegates; Allen County, four delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo, and Wayne-Union County societies, each two delegates; the other sixty-three county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, William R. Davidson, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, E. M. VanBuskirk, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, J. T. Oliphant, N. K. Forster, J. E. Ferrell, Floyd T. Romberger and Cleon A. Nafe; and ex-officio, the president, president-elect, executive secretary, and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Ray E. Smith, 1021 Hume Mansur Building, Indianapolis 4, Indiana, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 3:00 p.m., Monday, September 26, in the Murat Theater, Indianapolis, and again at 11:00 a.m., Thursday, September 29, in the auditorium, Athenaeum. (Luncheon meeting.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Address of president-elect.
6. Report of executive secretary.
7. Report of the treasurer.
8. Report of the chairman of the Council.
9. Reports of councilors.
10. Reports of standing and special committees:
 - (1) Executive Committee.
 - (2) Arrangements.
 - (3) Scientific Work.
 - (4) Public Policy and Legislation.
 - (5) Publicity.
 - (6) Medical Education and Hospitals.
 - (7) Public Relations.
 - (8) Auditing.

- (9) Cancer.
- (10) Centennial History and Publications.
- (11) Civic Relationship and Community Health Agencies.
- (12) Conference of County Medical Society Officers.
- (13) Conservation of Vision.
- (14) Constitution and By-Laws.
- (15) Crippled Children Services.
- (16) Diabetes.
- (17) Hard of Hearing.
- (18) Heart Disease.
- (19) Historical Exhibits.
- (20) History.
- (21) A.M.A. Campaign Coordinating Committee.
- (22) Indiana Inter-Professional Health Council.
- (23) Indigent Medical Care.
- (24) Industrial Health.
- (25) Instructional Courses.
- (26) Maternal and Child Health.
- (27) Medical and Nursing School Scholarships.
- (28) Mental Health.
- (29) Prepaid Medical and Hospital Insurance.
- (30) Rural Health.
- (31) School Health and Physical Education.
- (32) Scientific Exhibit.
- (33) State Fair.
- (34) Traffic Safety.
- (35) Tuberculosis.
- (36) Venereal Disease.
- (37) Veterans Affairs and Rehabilitation.
- (38) Journal Publication.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1949, and their successors must be elected at the session: Delegates to the American Medical Association to succeed F. S. Crockett, Lafayette, and William M. Cockrum, Evansville; and alternates, A. M. Mitchell, Terre Haute, and Cleon A. Nafe, Indianapolis.

Delegates from the third, sixth, ninth and twelfth districts are reminded that the terms of their councilors will expire December 31, 1949, and new councilors should be elected to succeed the following:

Third District: William H. Garner, New Albany.

Sixth District: W. U. Kennedy, New Castle.

Ninth District: Wemple Dodds, Crawfordsville.

Twelfth District: Paul A. Garber, South Whitley.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

RAY E. SMITH, *Executive Secretary.*

Reports of Officers and Committees

EXECUTIVE SECRETARY

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The popular advertising slogan of "something new has been added" might be applied appropriately to the executive offices of the association. Because of the ever-increasing volume of work, due principally to the campaign against socialized medicine and the many committee activities, a field secretary and another stenographer were added to the headquarters staff the past year.

Few of the members realize the extent of the association's activities. Fewer still are aware of the demands made upon the executive offices. The reasons for this situation are readily explainable. First of all, the association has thirty-eight committees, and most of them are active. In the second place, the membership is growing year by year, and more members are turning to the headquarters office for assistance. The secretary and his staff take great satisfaction in serving the members. It is a pleasure to receive inquiries, to have physicians come to the office, to ask for favors, et cetera.

Various projects of the association proper have grown amazingly in the past year, such as participation in, and contributing to, organizations allied with or related to medicine. For example, instead of one rural health conference this year, two were held; instead of one school health conference, six are planned.

What does all this mean? It means that your association is alive, is progressing, is making its influence felt.

No little time of the executive staff has been devoted to planning and handling details of the 100th annual convention, which promises to be an outstanding event.

The field secretary, Mr. James A. Waggener, has devoted the bulk of his time to date to Indiana's part in the fight against political medicine. Indiana is reported by Whitaker & Baxter, directors of the A.M.A.'s national educational campaign, to be among the states doing an excellent job. After the annual session Mr. Waggener expects to visit many of the county societies.

Your secretary wishes to express his appreciation for the friendliness and cooperation shown by the secretaries of the county medical societies who are called upon continually for information. We hesitate to send them so many bulletins, notices and letters, because they are so busy, but there seems to be no other way.

Miss Lucille Kribs, the assistant secretary; Mr. Waggener, the field secretary; Mrs. Isabella Rowlison, editorial secretary of THE JOURNAL, and the others in the headquarters office, join with

the secretary in thanking the association's officers and members for their kind consideration.

Physicians, like people in all walks of life, are concerned about the future. What it holds for the medical profession is uncertain in a world as unstable as ours. Members of the association can be certain, however, that whatever the future holds, their executive secretary and his staff will put forth every effort in their behalf.

RAY E. SMITH, *Executive Secretary.*

TREASURER

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The following report, prepared by George S. Olive and Company of Indianapolis, gives our financial statement as of December 31, 1948.

Since our last report we have been able to invest \$5,000 additional in United States Savings bonds, series G. These have been added to the general fund and are shown in the auditor's report.

On page 964 will be found the report of the Auditing Committee which met July 27, 1949, at the Indiana National Bank at Indianapolis.

The accountant's report is as follows:

January 10, 1949.

The Council,
Indiana State Medical Association,
Indianapolis, Ind.

Gentlemen:

We have examined the accounts and financial records of the Indiana State Medical Association for the year ended December 31, 1948, for the purpose of verifying the assets, liabilities, and fund balances at December 31, 1948, and of reviewing the income and expense accounts for the year then ended on a cash receipts and disbursements basis. In connection, therewith, we have reviewed the system of internal control and the accounting procedures of the Association, and have examined and tested accounting records and other supporting evidence, by methods and to the extent we deemed appropriate.

In our opinion, subject to the comments made herein, the accompanying statement of assets, all funds, and related statements of income and expense, on the basis of cash received and disbursed, present fairly the position of the Indiana State Medical Association at December 31, 1948, and the results of operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

GENERAL COMMENT

In exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1948, showing in summary form the sources from which this increase was derived.

The increase of \$13,073.88 resulted from an excess of operating cash receipts over operating cash disbursements in the general fund. Increases in the general fund are due mainly to additional income from exhibits and additional income from membership dues. Additional United States Savings Bonds in the amount of \$10,000 were purchased for the general fund. A complete analysis of the increases and decreases in the general fund is presented in exhibit C.

Details of the assets of all funds are presented in exhibit B. There were no recorded liabilities at December 31, 1948, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, which are kept in the Association's safe deposit box in the Indiana National Bank. Cash on deposit in banks was confirmed by direct correspondence with the depositories.

Analyses of the cash receipts and disbursements of the general fund, of THE JOURNAL of the Indiana State Medical Association, and of the Medical Defense Fund are presented in exhibits C, D, and E.

Yours very truly,
Geo. S. Olive & Co.,
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION
Analysis of Increase in Assets, All Funds,
Year Ended December 31, 1948

TOTAL ASSETS, DECEMBER 31, 1948—	
Exhibit B	\$80,646.23
TOTAL ASSETS, DECEMBER 31, 1947	67,572.35
NET INCREASE	\$13,073.88

Arising from the following sources:

Excess of operating cash receipts over operating cash disbursements, general fund, year ended December 31, 1948	
Receipts—	
Exhibit C	\$68,754.38
Disbursements—	
Exhibit C	64,137.74
	\$ 4,616.64
U. S. Government bonds purchased	10,000.00
	\$14,616.64

Excess of operating cash disbursements over operating cash receipts, The Journal of the Indiana State Medical Association, year ended December 31, 1948:	
Receipts—	
Exhibit D	\$40,380.05

Disbursements—	
Exhibit D	41,453.06
	(1,073.01)
Excess of operating cash disbursements over operating cash receipts, Medical Defense Fund, year ended December 31, 1948:	
Receipts—	
Exhibit E	\$2,980.25
Disbursements—	
Exhibit E	3,450.00
	(469.75)

TOTAL NET INCREASE \$13,073.88

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION
Statement of Assets, All Funds,
at December 31, 1948

GENERAL FUND:	
Cash on deposit—Exhibit C	\$16,195.94
Petty cash fund	200.00
Investments:	
Marion County Flood Prevention bonds	\$3,000.00
Indianapolis City Hospital bonds	5,000.00
U. S. Treasury bonds	8,000.00
U. S. Savings bonds	25,000.00
	41,000.00
Total general fund	\$57,395.94

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:	
Cash on deposit—Exhibit D	5,799.57
MEDICAL DEFENSE FUND:	
Cash on deposit—Exhibit E	2,450.72
Investments:	
Marion County Flood Prevention bonds	2,000.00
U. S. Treasury bonds	5,000.00
U. S. Savings bonds	5,000.00
U. S. Baby bonds	3,000.00
	15,000.00
Total Medical Defense fund	17,450.72

TOTAL ASSETS, ALL FUNDS—	
Exhibit A	\$80,646.23
Exhibit C	

INDIANA STATE MEDICAL ASSOCIATION
Comparative Statement of Cash Receipts and Disbursements,
Years Ended December 31, 1948,
and December 31, 1947

	Year Ended		
	Dec. 31 1948	Dec. 31 1947	Increase (Decreased)
CASH BALANCE AT BEGINNING OF YEAR	\$11,579.30	\$ 5,613.25	\$ 5,966.05
RECEIPTS:			
Membership dues	52,039.00	50,115.00	1,924.00
Income from exhibits	12,676.23	6,886.25	5,789.98
Interest income:			
U. S. Treasury bonds	212.50	212.50	-----
U. S. Savings bonds	437.50	250.00	187.50
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	-----

Marion County, Indiana, Flood Prevention bonds	127.50	127.50	-----
Meyer Nurse Scholarship fund	-----	600.00	(600.00)
Krannert Nurse Scholarship fund	800.00	400.00	400.00
Egbert Medical Scholarship fund	200.00	-----	200.00
Centennial book fund	930.80	-----	930.80
Refunds on annual session	875.94	306.25	569.69
Instructional courses	197.83	-----	197.83
Other refunds	57.08	-----	57.08
Check written off	-----	7.50	(7.50)
	68,754.38	59,105.00	9,649.38
BEGINNING BALANCE PLUS CASH RECEIPTS	80,333.68	64,718.25	15,615.43

DISBURSEMENTS:

Transfer of applicable portion of dues to The Journal of The Indiana State Medical Association—Exhibit D	10,970.00	7,198.00	3,772.00
Medical Defense fund—Exhibit E	2,630.25	2,586.75	43.50
Purchase of securities	10,000.00	5,000.00	5,000.00
Headquarters office expense	16,792.58	14,563.37	2,229.21
Publicity committee	1,361.00	771.59	589.41
Public policy	1,483.26	2,513.67	(1,030.41)
Council	1,750.79	6,392.10	(4,641.31)
Officers	639.33	915.78	(276.45)
Annual session	8,743.22	6,834.76	1,908.46
Miscellaneous committees	7,386.90	4,312.17	3,074.73
Federal old age benefits tax	81.88	76.88	5.00
Postgraduate study	456.04	191.77	264.27
Refunds of dues	12.00	-----	12.00
National conference on Medical Service	-----	7.63	(7.63)
Refunds on exhibit rent	181.25	31.25	118.75
Fifty-Year Club	234.67	1,143.23	(908.56)
Women's Auxiliary of I. S. M. A.	800.00	600.00	200.00
General practitioner award	61.01	-----	61.01
Instructional courses	2.00	-----	2.00
Field secretary	551.56	-----	551.56
	64,137.74	53,138.95	10,998.79

CASH BALANCE AT END OF YEAR-----\$16,195.94 \$11,579.30 \$ 4,616.64

Exhibit D**INDIANA STATE MEDICAL ASSOCIATION**

**Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1948**

The Journal of the Indiana State Medical Association

BALANCE, JANUARY 1, 1948----- \$ 6,872.58

RECEIPTS:

Subscriptions — members—Exhibit C	\$10,970.00
Subscriptions—non-members	449.50
Advertising	28,497.76
Collections on accounts receivable	90.00
Single copy sales	222.50

Electrotypes	150.29
Total receipts—Exhibit A	40,380.05
	47,252.63

DISBURSEMENTS:

Salaries	10,957.87
Printing	26,391.00
Office postage	353.30
Journal postage	525.97
Advertising commissions	229.50
Electrotypes	644.09
Refurbishing	439.39
Press clippings	129.64
Editor and editorial board expense	88.93
Office supplies	788.09
Rent	480.00
Electricity	25.93
Telephone and telegraph	219.25
Federal old age benefits tax	68.47
Miscellaneous	112.63

Total disbursements—Exhibit A ----- 41,453.06

BALANCE, DECEMBER 31, 1948
Exhibit B ----- \$ 5,799.57

Exhibit E

**INDIANA STATE MEDICAL ASSOCIATION
Statement of Cash Receipts and Disbursements,
Year Ended December 31, 1948
Medical Defense Fund**

BALANCE, JANUARY 1, 1948----- \$2,920.47

RECEIPTS:

Transfer of applicable portion of dues from the general fund—Exhibit C	\$2,630.25
Interest income:	
U. S. Treasury bonds	140.00
U. S. Savings bonds	125.00
Marion County Flood Prevention bonds	85.00

Total receipts—Exhibit A ----- 2,980.25
5,900.72

DISBURSEMENTS:

Malpractice fees	1,650.00
Attorney fees	1,800.00

Total disbursements—
Exhibit A ----- 3,450.00

BALANCE, DECEMBER 31, 1948
—Exhibit B ----- \$2,450.72

A. F. WEYERBACHER, M.D., *Treasurer.*

CHAIRMAN OF THE COUNCIL

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

It becomes my duty, as chairman of the Council, to present a report to your honorable body. Minutes of the Council meetings on October 26, 1948, and October 28, 1948, appeared in the last December JOURNAL; minutes of the January 16, 1949,

meeting were printed in the March JOURNAL; minutes of the April 10, 1949, meeting were carried in the May JOURNAL, and the September JOURNAL contains minutes of the July 31, 1949, Council session. Due to this fact, I will not burden you with a detailed recital of Council actions.

As a member of the Council for some years, and as chairman in 1947, 1948 and 1949, I have been privileged to observe the inner workings of the association from a front-row seat. The multitude of problems facing medicine today is amazing. On every side, it seems, our profession is beset with perplexing difficulties, and more and more questions are coming before the Council for determination.

The Council, as the policy-making body of this organization when the House of Delegates is not in session (the delegates meet in regular session only twice a year), is charged with a grave responsibility. The councilors should be supported in their endeavors to do what is best for medicine. Every member of the association, in fact, should take an interest in our association's affairs. The Council will appreciate the advice and counsel of the membership.

One of the greatest needs of our association is for members to be better informed on the A.M.A. and I.S.M.A. programs and the "do's" and "don't's" of medicine in its battle for survival. May I urge every doctor to keep abreast of developments by reading the A.M.A. and I.S.M.A. journals diligently, by attending county, district and state medical meetings, and by serving to the full extent of his ability when given a committee assignment?

Each councilor is cognizant of his deep obligation, and approaches each decision he is called upon to make with serious thought. I am confident that the welfare of medicine and the future of the association are in good hands.

ALFRED ELLISON, M.D., *Chairman.*

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

The most activity in the First District has centered around the Post Graduate Session held monthly at Evansville and sponsored jointly by the Vanderburgh County Medical Society and the Indiana State Medical Association. These sessions have covered practically every aspect of medicine and surgery, with prominent men from far and wide acting as moderators and special guest speakers. These sessions have been well attended and many favorable comments have been received about them.

Many young doctors have entered practice in the district, at least three in rural areas.

Hospital facilities have been taxed at times, but are somewhat improved at this time. Ample applications for nurses training have been obtained in the hospitals of the area for the coming year. This situation was aided by high school talks, radio, and open house get-togethers of eligible students and nursing procurement personnel.

H. T. COMBS, M.D., *Councilor.*

SECOND COUNCILOR DISTRICT

All but two of the component societies of the Second District have been visited since the first of the year. Those remaining will be visited this fall. All societies in this district are well organized and are alert to the problems of the times.

Replies to a questionnaire, as well as personal visitation, have shown that the individual doctors are active in carrying our message to the public. Many have done so by word of mouth—talking with their patients day after day. Others have written letters to their own Congressmen and Senators. Some societies have sponsored newspaper advertisements carrying plain talk and facts concerning socialized medicine to the public. Radio talks and panel discussions have been held by some of our societies. This latter medium is not without danger as doctors generally are not experienced public speakers and they may not be able to cope with some glib professor who has perfected himself in the technique of radio debate.

The questionnaire also revealed that round-the-clock medical service is being provided in all of our counties. In some smaller counties this is no new problem—they have always provided such service. Other counties have set up an emergency roster with the local hospital or with a Doctors' Exchange Service, so that a real emergency will never be allowed to want for prompt care. Some societies have adopted the idea of half of the members taking one afternoon off while the other half take off a different afternoon, thus providing the public with doctors in their offices every day in the week.

Membership in the Second District shows a slight gain over the previous year, but our district is one of the smaller ones, standing tenth in point of numbers in the thirteen districts. Our district meeting was held the afternoon and evening of June 2 at the Elks Country Club, Sullivan. Every county was represented and the total registration was about fifty. The State Board of Health provided an interesting and instructive program. Our association's president-elect, Dr. C. S. Black, was present and made a very favorable impression by his earnest and logical remarks concerning our present-day problems.

WILLIAM C. REED, M.D., *Councilor.*

THIRD COUNCILOR DISTRICT

The Third District had its annual meeting at Corydon, on May 25. It was a fitting place for the meeting, for it was here 100 years ago that the first meeting of the association was organized. Dr. A. P. Hauss, president of the Indiana State Medical Association, gave us some early history of the important part played by the physicians of the Third District. The guest speakers were from Louisville, who presented one paper on "Endocrinology," and one on "Obstetrics." There was a good attendance.

The officers for the next year were chosen: Dr. E. P. Buckley, president, from Jeffersonville, and Dr. Eli Goodman, secretary, from Charlestown. The next annual meeting will be in Jeffersonville, May, 1950.

The County Medical Societies are functioning in all the counties except Crawford. They have decided to join with the nearby counties. Two of the physicians will unite with Harrison County Medical Society and one with the Orange County Medical Society.

The educational program against socialization is being well accepted by the physicians and the public is working with us in a most gratifying manner.

WILLIAM H. GARNER, M.D., *Councilor*.

FOURTH COUNCILOR DISTRICT

The yearly meeting of the Fourth District was held at the Ohio-Dearborn Country Club on May 25, 1949. A golf tournament was held in the morning, a scientific program was given in the afternoon and a banquet with a very interesting after-dinner speaker was held for the doctors and their wives that evening.

Much interest is expressed by both laity and the doctors in this district over the national health program and it seems there is a good response by the laity against the national health program.

GEORGE A. MAY, M.D., *Councilor*.

FIFTH COUNCILOR DISTRICT

The Fifth District Medical Society met at the Elks Club in Brazil, on May 25, 1949. A scientific program was held in the afternoon at which Dr. Irvin Scott, of Sullivan, read a paper illustrated with moving pictures on a new method of pinning fractures of the hip. Dr. Carl Huber, of the Indiana University Medical Center at Indianapolis, gave a talk on delivering of babies. Dr. John Warvel of Indianapolis gave a talk on "Fundamental Concepts of Diabetes."

Dinner was served at 6 o'clock at which time Dr. Warren Draper, national director of the medical and welfare program of the United Mine Workers of America, gave a talk on the workings of this plan for caring for the miners and their families. Dr. Asa Barnes, regional director from Louisville, also gave a talk. Mr. J. A. Waggener, field secre-

tary, gave a short talk, and Mr. R. E. Saylor, of Mutual Medical Insurance, Inc., gave a talk.

All of the societies in the district are functioning and doing everything they can to carry out the educational program of the American Medical Association, with Clay County running a series of articles in the newspaper informing the people of medical care.

Dr. M. C. Topping was elected president, Dr. S. R. Combs, secretary, with the next meeting to be held at Terre Haute.

ALBERT M. MITCHELL, M.D., *Councilor*.

SIXTH COUNCILOR DISTRICT

The Sixth District has had a very active experience. The component societies, without exception, have had regular meetings, with excellent programs, and with particular stress on the social phase. They have found that frequent social meetings improve the medical standards by uniting men in a more intimate acquaintance. Friction and factionalism are nonexistent, and this high degree of friendly, personal relations have made possible unique solidarity of action and intensive effort in a highly successful campaign against compulsory medicine. We are fortunate in having as a member of Congress for this district Mr. Ralph Harvey, who, by personal belief, has become a leader in his district, and in the Congress, in soliciting support of the doctors' viewpoints. This district was the first in the state, and almost in the nation, to set up a very active campaign to inform the profession of the precise details of the various health bills, and upon that knowledge and interest the local profession instituted a vigorous effort of public information, by letters, by group talks, and by public advertisements. In most of the counties better public relations have been actively sought by setting up round-the-clock emergency service, by cooperation with County Welfare Boards in setting up medical programs for the indigent, and by Cancer Detection Clinics in each county, and by active participation in all public health movements, such as the tuberculosis, crippled children, polio, heart, and cancer movements. Politically, we have the support of all our elective legislators, both state and national.

During the year several special district meetings were held, which were splendidly attended by various officers, which were devoted entirely to politics.

The new Rush County Hospital is building and will be open by January 1.

The Hancock County Hospital funds have been raised and building completion will be in 1950.

Fayette County and Wayne County are building hospital additions.

Henry County is planning for either a hospital addition or a convalescent building.

Also under consideration is an Old Peoples Home to provide domiciliary care for both private and Welfare Board needs. Both private and public funds will be solicited.

The annual meeting at New Castle, in May, was well attended, with an excellent program, and honored by the attendance and talk by President Hauss. The present Councilor was re-elected.

W. U. KENNEDY, M.D., *Councilor*.

SEVENTH COUNCILOR DISTRICT

Two successful meetings—in Franklin on September 22 and in Indianapolis on May 10—marked the 1948-1949 activities of the Seventh District Medical Society.

The September session at the Johnson County Country Club saw the elevation of Dr. Malcolm Scamahorn, of Pittsboro, into the president-elect's chair. Dr. Don E. Wood, of Indianapolis, was re-elected secretary-treasurer. Dr. Horace M. Banks, of Indianapolis, assumed the presidency from Dr. Harry Murphy, of Franklin, at the meeting.

Outstanding feature was an evening dinner address by Mr. Eugene C. Pulliam, president of Indianapolis Newspapers, Inc., who gave a first-hand account of his observations of the impact of socialism on the European countries and England, especially as it concerned the deterioration in the quality of medical care.

An afternoon golf tournament also was held, and a scientific program featured Dr. James O. Ritchey of Indianapolis, who talked on "Diseases of the Liver—Medical or Surgical." Discussants were Drs. John H. Warvel, of Indianapolis, and William D. Province, of Franklin.

One hundred and thirty members, their wives and guests were in attendance.

The May meeting, held in Methodist Hospital's White Cross Guild room, was devoted to Hoosier-born and educated Dr. Frank C. Mann of the Mayo Clinic, who read a paper on "Experimental Studies on the Kidney." Preceding the scientific program, a dinner in Dr. Mann's honor was held in an Indianapolis club.

Every effort is being made to encourage physicians to participate in the fight against government medicine, by having them distribute literature and talk with their patients.

C. J. CLARK, M.D., *Councilor*.

EIGHTH COUNCILOR DISTRICT

Each county society in our district has been very active during this year. Chief emphasis has been directed toward the matter of governmental medicine and need for more hospital facilities.

The annual meeting was held at the Delaware Country Club on May 18, 1949. An afternoon and evening session was arranged for, with Dr. Frederic Brown, Fort Wayne; Dr. Robert L. Glass, Indianapolis, and Dr. Russell A. Sage, Indianapolis, as speakers, on the program.

President Hauss and James A. Waggener were guests.

Dr. Ivan Brenner of Winchester was elected president and Dr. Charles Gullett of Union City, secretary and treasurer.

Doctor Brenner announced that the 1950 meeting will be held in Muncie at the Delaware Country Club.

E. H. CLAUSER, M.D., *Councilor*.

NINTH COUNCILOR DISTRICT

The annual meeting of the Ninth District Medical Society was held at Tipton, on May 25, 1949. Many of the physicians participated in a golf tournament and the efficiency of our hosts was indicated by the fact that all participants were awarded prizes. Luncheon for the ladies was served at the Christian Church at Tipton. This was followed by bridge, golf or a movie during the afternoon.

The meeting of the delegates was called to order by President William A. Kurtz, at noon. A resolution opposing Federal Compulsory Health Insurance was passed unanimously by the delegates assembled and was transmitted to the President of the United States and all Senators and Representatives from the state of Indiana. Dr. Wemple Dodds of Crawfordsville was re-elected councilor for a term of three years. The 1950 meeting is to be held in Benton County.

An excellent scientific program was held in the afternoon. The speakers were Drs. William M. Dugan, Charles O. McCormick, Jr., and Russell Hippensteel, all of Indianapolis.

A banquet was held at the Moose Lodge in Tipton at 6:00 P.M. Approximately 90 laymen attended the banquet, which was followed by an address by Mr. Albert Stump, entitled "Pills and Politics."

During the past year there is every evidence of increased activity on the part of the county societies in this district. The larger societies have been aggressive in combating the inroads of government into medicine.

Speakers' bureaus have been set up and local Public Relations Committees established and there is every evidence of active cooperation with the various committees of the Indiana State Medical Association.

WEMPLE DODDS, M.D., *Councilor*.

TENTH COUNCILOR DISTRICT

Activity in the Tenth District to combat the threat of government medicine has been excellent. Office posters and a campaign in individual physicians' offices to solicit the help of patients has had fine results. Several thousands of letters and postcards have been sent to Congress protesting Compulsory Sickness Insurance. Most of the large organizations in the area, including some labor unions, have invited speakers in to explain the profession's views.

A group accident and health insurance policy for the physicians of Lake County has recently been broadened, with the consent of the Executive Committee of the Indiana State Medical Association, to take in any physician in the district whose own county society has no plan available. This has

been accomplished with a nonvoting, nondues-paying special membership in the Lake County society, which will not conflict with other county society memberships.

The October meeting of the district saw Dr. Paul Vietzke of Valparaiso elected as president, and Dr. Carl Davis of the same city named secretary. That meeting, which was held at Whiting, began with a tour of the Standard Oil Company's world's largest oil refinery, and ended at Phil Smidt's Restaurant. Following dinner, Dr. Archibald Hoyne, of Chicago's Municipal Contagious Diseases Hospital, spoke on the subject, "Poliomyelitis," during which he recited the knowledge gained from the 1948 season. At this meeting it was decided to assess each doctor in the district fifty cents to defray the incidental expenses of the district meetings.

The March meeting was held at Teibel's Restaurant in Schererville. It was at this meeting that the anti-socialized medicine campaign was given its biggest impetus. The speaker of the evening was Dr. A. C. Ivy, vice president of the University of Illinois, who described government medicine as he had seen it practiced in European countries. Doctor Ivy also spoke on the subject, "The Etiology of Ulcers."

The 1949 Fall meeting has been set for Tuesday, October 11, at the new Marshall House in Gary. Dr. Paul Hawley, National Commission Director of the Associated Medical Care Plans, will discuss recent developments in government medicine legislation and the progress being made by voluntary health insurance plans to meet the threat. Because of the reputation enjoyed by the speaker, guests will be invited, including the dentists in the area. The usual rule against press and radio coverage will be waived for this meeting.

WILLIAM H. HOWARD, M.D., *Councilor*.

ELEVENTH COUNCILOR DISTRICT

Attendance and interest were good at the spring meeting held May 18, 1949, at Logansport. The general topic of this meeting was "Tropical Medicine in Indiana," and the subject was well covered by the speakers, Drs. John R. Brayton, J. L. Arbogast, L. T. Coggeshall, and James Browning.

Election of officers resulted in selection of Dr. F. M. Whisler of Wabash for president, Dr. O. G. Brubaker of Manchester re-elected for secretary-treasurer, and Dr. E. R. Clarke of Kokomo as councilor, to fill out the term of Dr. C. S. Black.

We are trying to keep the various component societies informed as to the requests made by the state headquarters. Several of them have started round-the-clock medical service programs. Here in Howard County we are in process of arranging a deal with the local hospital, which we felt was the logical place to set up the plan.

E. R. CLARKE, M.D., *Councilor*.

TWELFTH COUNCILOR DISTRICT

All of the component County Societies of the district are active and in good condition.

We had a good attendance and an excellent scientific program at our annual meeting, which was held in Fort Wayne on April 5.

The scientific program was presented by Dr. C. O. McCormick, Indianapolis; Dr. Manual E. Lichtenstein, Chicago; and Dr. Willard O. Thompson, Chicago.

The following officers were elected for the next year: Dr. Karl M. Beierlein, president; Dr. Arthur R. Savage, vice-president; and Dr. William J. Gerding, secretary-treasurer. Dr. M. B. Catlett was elected councilor for three years, beginning January 1, 1950.

PAUL A. GARBER, M.D., *Councilor*.

THIRTEENTH COUNCILOR DISTRICT

The affairs of the eight counties of the Thirteenth District are in good condition. The occasional difficulties which arise have been handled with order and propriety by the various county societies, indicating good organization and a splendid spirit of cooperation. The annual meeting was held November 10 in South Bend. The morning session was taken up with a discussion of pathological subjects at the South Bend Medical Foundation. The afternoon and evening were spent in the discussion of scientific subjects by various speakers. President C. A. Nafe and Executive Secretary Ray E. Smith attended this meeting and each made a short talk.

ALFRED ELLISON, M.D., *Councilor*.

EXECUTIVE COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Eleven meetings of the executive committee—two more than last year—were held between August 1, 1948, and August 1, 1949, to transact the large volume of business that comes before the committee. The minutes of these meetings appeared in THE JOURNAL and the committee's actions are presumed to be well understood.

At every meeting the committee was confronted with a long agenda, which necessitated deliberations until after midnight on some occasions. Whenever it was possible to delay decision until the next meeting of the Council, the subjects under discussion were referred to the Council.

It would be tedious, and serve to no avail, to go into minute detail in this report. The paramount decisions and actions of the committee were:

1. Recommendation to the Council that the by-laws be amended to set aside \$1.25 from each membership for the Medical Defense Fund.

2. Worked out an out-patient fee schedule with the dean of the Indiana University School of Medicine to keep full-time professors on the medi-

cal school faculty from competing with physicians in private practice, and placing the medical school in the practice of medicine.

3. Interviewed applicants and recommended individual for field secretary position.

4. Sponsored meeting with allied groups and interested these groups in joining with association in waging campaign against socialized medicine.

5. Created Indiana A.M.A. Campaign Coordinating Committee to direct drive in state.

6. Procured assurance from the director of concessions that medical quacks will not be permitted at the 1949 state fair.

7. Conferred with Woman's Auxiliary leaders to develop a program and better coordination between the auxiliary and the state association.

Membership Report

The membership of the association on August 1, 1949, stood at 3,693, the highest in history.

Comparative membership figures for the last five years follow:

Year	Number of Physicians in Indiana	Regular Members	Honorary Members	Total Members
1945	4,165*	3,187**	142	3,329
1946	4,165	3,251***	155	3,406
1947	4,165	3,374****	172	3,546
1948	4,165	3,438*****	177	3,615
1949	4,165	3,505*****	188	3,693

* Figure taken from the latest directory of the American Medical Association.

** Includes 1,109 men in service who received membership gratis.

*** Includes 831 men in service who received membership gratis.

**** Includes 117 men in service who received membership gratis.

***** Includes 55 men in service who received membership gratis.

***** Includes 36 men in service who received membership gratis.

The Journal

After nine years of mounting JOURNAL costs, there is—at long last—an indication of a turn in the opposite direction. Figured on cost plus 20 percent for overhead and profit, C. E. Pauley & Co., the printers, have been able to bring the costs under the contract price of \$19.25 per page, and have given us the benefit of this saving.

But the finances of THE JOURNAL remain our biggest headache. What we may have gained in reduction in production costs is offset by the drop in revenue from advertising. Every magazine, of course, is faced with this situation, but they have been able to operate at a profit by enormous increases in subscription rates. THE JOURNAL is now allowed \$3.00 from each member's dues against \$2.00 a year ago, which is a lesser percentage of subscription increase than that of privately-owned magazines.

Despite the financial situation, it has not seemed prudent to lower the standards of THE JOURNAL, recognized as one of the best state medical journals issued. This is an unusually expensive year for

THE JOURNAL, too, because of the large amount of material which must necessarily be carried because of the centennial convention.

Below are figures revealing price-per-page increases of THE JOURNAL:

1940—\$ 5.20 (This price prevailed until 1945)

1945—\$ 6.75

1946—\$10.80 (First six months)

—\$11.54 (Last six months)

1947—\$13.25

1948—\$15.25

1949—\$19.25

The table below shows how total printing costs have risen:

Year	Cost	Number of pages (Without inserts)
1945	\$12,042.36	1,288
1946	21,283.49	1,476
1947	24,790.34	1,462
1948	26,391.00	1,380
1949 (6 months)	12,658.82	606

The following table shows the number of JOURNAL pages for the past six years:

Year	Per Cent Read- ing	Per Cent Read- ing	Adv. Pages	Per Cent Adv.	Total Pages	Aver. Pages Per Issue
1943	736	59	516	41	1252	104.1
1944	758	56	588	44	1346	112.1
1945	580	44	754	56	1334	111.1
1946	696	46	824	54	1520	126.7
1947	681	45	837	55	1518	126.5
1948	703	49	707	51	1410	117.5

Advertising

As has been said previously, advertising volume is down. Letters were mailed to 750 business firms soliciting advertising for the July JOURNAL (Roster Number). The advertising sold through these letters totaled \$588.90 against \$836.75 which was obtained by the same means in 1948. An advertising solicitor has been engaged to sell space for the Convention Issue in September.

A comparison of advertising revenue for the first six months of the last four years with a like period for 1949, follows:

First Six Months	1946	1947	1948	1949
From A.M.A.				
agency --	\$ 8,459.62	\$ 9,779.78	\$ 8,743.76	\$ 8,133.26
Direct to JOURNAL -	4,295.43	5,167.11	5,066.43	4,564.23
Total --	\$12,755.05	\$14,946.89	\$13,810.19	\$12,697.49

New Editors

The retirement of Dr. E. M. Shanklin, of Hammond, as editor, after sixteen years of faithful service, became effective January 1, 1949. He was succeeded by Dr. Frank B. Ramsey, of Indianapolis, who was associate editor at the time. Dr. A. W. Cavins, of Terre Haute, was elected associate editor by the Council.

Doctor Shanklin is now serving as Editor Emeritus and THE JOURNAL is proud to carry his name at the top of its editorial mast head.

Four Special Numbers

Between August 1, 1948, and August 1, 1949, THE JOURNAL issued four special numbers: General Practice, August, 1948; Convention, October, 1948; Cancer, April, 1949; and Medical Yearbook, July, 1949. In June, 1949, THE JOURNAL began the publication of ONE HUNDRED YEARS OF INDIANA MEDICINE in serial form, which was completed in the August, 1949, issue.

Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1948, the following eleven cases were pending before the committee, three of which were closed during the year, leaving eight cases still pending:

Case No. 200—Suit filed February 2, 1932. Pending.

Case No. 241—(Closed). Suit filed February 7, 1941. Three days' trial, resulting in verdict for defendant. Expense, \$562.50, paid April 26, 1949.

Case No. 249—Suit filed January 6, 1944. Awaiting assignment for trial.

Case No. 251—Suit filed September 25, 1942. Pending.

Case No. 252—Suit filed August, 1944. Awaiting assignment for trial.

Case No. 255—Suit filed September, 1945. Awaiting assignment for trial.

Case No. 256—Suit filed February 27, 1946. Awaiting ruling of the court on a motion to make more specific.

Case No. 260—(Closed). Suit filed July, 1946. Final compromise and settlement, December 9, 1948. Expense, \$225.00, paid December 20, 1948.

Case No. 264—Filed January 28, 1948. Pending in court on motion to make more specific.

Case No. 266—Suit filed March 17, 1948. Pending on motion to make more specific.

Case No. 267—(Closed). Filed September 10, 1947. Settled for \$1,000.00 and dismissed January 11, 1949. Expense, \$450.00, paid April 26, 1949.

Since August 1, 1948, and up to August 1, 1949, the following new case has come before the committee, making a total of nine cases pending at the present time as against eleven unclosed cases at the same time last year:

Case No. 268—Suit filed September 7, 1948. Pending.

The following case was closed prior to August 1, 1948, but as statement for attorney's fees was received and paid *after* that date, this case is listed again this year:

Case No. 242—(Closed). Suit filed January 28, 1942. Dismissed January 9, 1948. Expense, \$250.00, paid March 4, 1949.

2. Medical Defense Fund Statement, from August 1, 1948, to August 1, 1949:

Balance, August 1, 1948----- \$3,227.73

Receipts:

Dues,	73—1948 members--	\$	54.75	
	3,507—1949 members--		2,630.25	2,685.00

Interest on bonds -----		350.00
-------------------------	--	--------

\$6,262.73

Disbursements:

Malpractice fees -----	\$1,487.50
Salary of Association attorney	1,800.00
Treasurer's bond -----	37.50
	<u>3,325.00</u>

Balance in Medical Defense Fund

checking account, August 1, 1949----- \$2,937.73

C. H. McCASKEY, M.D., *Chairman*,
WALTER L. PORTEUS, M.D.
AUGUSTUS P. HAUSS, M.D.
CLAUDE S. BLACK, M.D.
ALFRED ELLISON, M.D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

House of Delegates,

Indiana State Medical Association,

Gentlemen:

The battle over legislation has raged on two fronts this year—at Indianapolis and Washington. The "Battle of Indiana" was won in the 1949 Indiana General Assembly when the chiropractic bill met defeat after being amended to set up a commission to make a survey of Indiana chiropractic colleges. The author of the original bill made the motion that killed the bill by recommitment to committee.

The drugless practitioners continue to ask the legislature to grant them separate licensing boards so they can escape the six-years-after-high-school standards of education required by the State Board of Medical Registration and Examination for persons who would practice the healing art. They are coming back to the 1951 legislature with the same insistent demands. We will continue to oppose any legislation which would lower educational qualifications.

A full report of the legislative session was carried in the April issue of THE JOURNAL under the caption, "Indiana Medicine Weathers Stormy Legislative Session."

The chiropractors are active in veterans organizations, trying to use them to promote their special interests. The technique is to get resolutions passed asking the Veterans Administration to recognize chiropractic, the state legislature to vote them a special licensing board, et cetera. Physicians are urged to interest themselves in the veterans groups.

Physicians should bear in mind that twenty-five of the state senators are holdovers, and that many of the other twenty-five whose terms ended, as well as the hundred members of the 1949 House of Representatives, will run for re-election and may be in the 1951 session. From now until the next legislative session physicians should make an effort to know these legislators intimately. It will place us in a better position to approach them on health measures.

The committee is now working on a plan to inform the people better about the need for strict enforcement of the licensing laws. The first activity in this direction was the adoption by the Indiana Public Health Association, composed of 455 individuals and 13 corporate bodies, of a resolution upholding the high educational standards set by the state medical registration board, and commending the board for its efforts to prosecute unlicensed practitioners of healing.

"The Battle of Washington" is familiar to every doctor. Medicine is being attacked on many fronts, and while it is believed that we gained ground this year, the fight is far from won. The Indiana A.M.A. Campaign Coordinating Committee, created by the Executive Committee earlier this year, is handling Indiana's part in the fight against socialized medicine. Our committee has sent numerous letters and telegrams to Indiana Senators and Congressmen for and against other bills before the Congress. This is done in conformity with advice from the A.M.A.

We pledge to "keep up the good fight" in behalf of Indiana medicine.

J. WILLIAM WRIGHT, M.D.,

DONALD E. WOOD, M.D.,

Co-chairmen,

JOHN M. PARIS, M.D.

JOHN E. WYTENBACH, M.D.,

WILLIAM CHALLMAN, M.D.,

WILL THOMPSON, M.D.,

J. R. DOTY, M.D.,

HAROLD J. HALLECK, M.D.,

EUGENE F. BOGGS, M.D.,

GEORGE L. REGAN, M.D.,

JAMES L. WYATT, M.D.

COMMITTEE ON PUBLICITY

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Meeting every two weeks throughout the year, with but two exceptions, the Committee on Publicity has handled all newspaper releases, radio programs, and placed a number of speakers as it transacted its business.

The usual "Hints on Health" releases for weekly papers, now appearing in 151 papers, have been continued, and the fifteen-minute health broadcast over WFBM, Indianapolis, has been carried on. The customary spot news stories have been given to the press from time to time.

Before the Indiana A.M.A. Campaign Coordinating Committee was appointed, in March, speakers on socialized medicine were supplied to a number of organizations. A series of radio programs on the subject were suggested by the committee, but not enough county medical societies wanted to buy radio time to warrant the expense, so the project was dropped.

Until taken over by the Executive Committee, the Committee on Publicity served in an advisory capacity to the Woman's Auxiliary. Now relieved of this responsibility, the committee has more time to devote to other matters.

"Hints on Health"

While it is important that accurate and proper information on medical subjects be given the lay public, the committee's work is more routine than glamorous.

"Hints on Health" columns released during the year were:

Infant Deaths.	Walk, Don't Run.
Lung Cancer.	Nervous Stomach.
Appendicitis.	That Let-Down Feeling.
Hearing Aids.	Recipe for Long Life.
Accidental Deaths.	Time for Inventory.
Childbirth.	Oh, What's the Use?
Scarlet Fever.	Gout.
The Family Doctor.	Poison Accidents.
Taking Medicine.	Cancer of the Mouth.
Lye Poisoning.	Vital Food.
Stomach Function.	Housecleaning Made Easy.
Rheumatic Diseases.	Blessing in Disguise.
Thumb-Sucking.	Beware of Bursitis.
Bad Breath.	The Baldness Racket.
Hazards in the Home.	Insomnia.
Biting the Nails.	Wisdom of Age.
Winter Clothing.	Spotted Fever.
The Common Cold.	Childbirth Recovery.
Eardrum Damage.	Teething Time.
Broken Bones.	Chickenpox.
Stuttering.	Body Compensation.
Watch Your Step.	Farm Safety.
Athlete's Foot.	Watch the Heat.
Convulsions.	Automobile Safety.
Trench Foot.	Varicose Veins.
Increased Years.	The Larynx.

General Releases

Special news releases cleared by the committee were:

Doctor's Day at the Workshop in School and Community.

Health Education.

Nursing School Scholarships Awarded to Three Girls.

Blood Pressure Readings Taken at State Fair. School Health Conference (two releases).

State Convention (nine separate releases).

Doctors Caution Women Shoppers to Take it Easy.

Hoosier Doctors on A.M.A. Program at Atlantic City.

The Licensed Nursing Home and the Physician.

Uncle Sam May Pay Doctor Bills, But He Will Use Your Tax Money.

Radio Program

WFBM, Indianapolis, continued to carry the transcribed health series procured from the Bureau of Health Education of the A.M.A. The subjects used were:

Medicine Serves America.
Dodging Contagious Disease.
That Wonderful Feeling.
The Story Behind the Discovery.

Book Distributed

Copies of Lawrence Sullivan's book, *The Case Against Socialized Medicine*, were purchased and distributed to the county medical society secretaries and twenty-three college libraries. Five thousand copies of extracts from a speech by Dr. Herman B Wells, president of Indiana University, entitled, "How Medical Service Has Deteriorated in Germany Under Socialized Medicine," were ordered printed by the committee, and were distributed in the campaign against government medicine.

Speaker Supplied

Many speaking engagements were filled by the committee, but they came so thick and fast, particularly from groups wanting to hear about socialized medicine, that not all were recorded. Albert Stump, association attorney; the executive secretary; field secretary; Wray E. Fleming, counsel for the Hoosier State Press Association, and many others took part in the speaking. In the late weeks the campaign committee has done this booking.

A list of organizations supplied with speakers follows:

1948

October 15—Cass County Medical Society, Logansport.
November 16—Rotary Club, Bloomington.

1949

January 7—Woman's Auxiliary to the Howard County Medical Society, Kokomo.
January 11—Kiwanis Club, Frankfort.
February 2—Woman's Auxiliary, Marshall County Medical Society, Plymouth.
January 25—Veterans of Foreign Wars, Tyndall Towne, Indianapolis.
January 28—Woman's Club, Delphi.
February 15—Knox County Medical Society, Vincennes.
February 23—Purdue University Extension Forum, Indianapolis.
February 24—Chamber of Commerce, New Castle.
February 28—Business and Professional Woman's Club, Delphi.
March 1—Orange County Medical Society, West Baden.
March 9—Public meeting, Kokomo.
March 11—Putnam County Medical Society, Greencastle.
March 14—University Club, Anderson.
March 15—Delaware-Blackford County Medical Society, Muncie.
March 16—Kiwanis Club, Connersville.
March 17—Henry County Medical Society, New Castle.

March 17—Parent-Teacher Association, School No. 1, Indianapolis.
March 22—Indiana University Nurses Alumnae Association, Indianapolis.
March 22—Rotary Club, Vincennes.
March 24—Business and Professional Women's Club, Indianapolis.
March 26—Regional Conference of Boys' Club, Indianapolis.
March 29—Woman's Auxiliary to Indianapolis Medical Society, Indianapolis.
March 29—Kiwanis Club, Greenfield.
April 4—Robinson-Ragsdale Post, American Legion, Indianapolis.
April 5—Cooperative Club, Indianapolis.
April 7—Fountain-Warren County Medical Society, Kingman.
April 12—Kiwanis Club, Winchester.
April 13—Business and Professional Women's Club, Huntington.
April 15—Rotary Club, Lebanon.
April 18—Woman's Auxiliary, Legion Post No. 3, Indianapolis.
April 19—49'ers Club, Indianapolis.
April 20—Hayward-Barcus Post No. 55, American Legion, Indianapolis.
April 20—Parent-Teacher Association, School 15, Indianapolis.
April 21—Indiana Association of Podiatrists, LaPorte.
April 22—Quincy Club, Speedway City, Indianapolis.
April 25—Lions Club, Franklin.
April 25—Delta Upsilon Alumni Association, Indianapolis.
May 11—Parent-Teacher Association, School 66, Indianapolis.

The Committee on Publicity has benefited this year by having the editor of *THE JOURNAL* as a member. He has tossed into the discussions the propriety of using certain material submitted for publication, and his membership on the committee has been helpful to him, and his advice has been useful to the committee. It has been regretted that the president could not attend the meetings because of his distance from Indianapolis.

JAMES O. RITCHEY, M.D., *Chairman*,
HOMER G. HAMER, M.D.,
MARLOW W. MANION, M.D.,
FRANK B. RAMSEY, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Medical Education and Hospitals met in formal session July 13, 1949, to consider matters referred for its action.

The question of planning a postgraduate educational program for our association was discussed

at length. A study of the plans used by other states (of which there are few) was made. It was agreed that a program used by our state would differ from that used by any other state because the facilities and needs are unlike in each state. It was felt, however, that we should cooperate with and seek guidance from the A.M.A. Council on Medical Education.

By motion, the committee adopted the following recommendation that:

1. A program of postgraduate education should be a cooperative effort between the Indiana State Medical Association, Indiana University School of Medicine, Indiana State Board of Health and other interested agencies. That the state association, through this committee, should take steps to correlate these activities.
2. Several districts should be selected by the Council upon recommendation of this committee for extensive postgraduate courses of study.
3. The mechanics of operation of these courses should be under the direction of our field secretary, with the support and help of the councilor district and associate county medical societies.
4. A fee not to exceed twenty-five dollars (\$25.00) should be charged for the series of courses.
5. Qualified instructors should be paid an honorarium, not to exceed fifty dollars (\$50.00) and expenses, for each day spent in participating in this program.
6. Five thousand dollars (\$5,000) be appropriated for meeting the expense of this program, hoping that the majority of this will be repaid by fees charged for these courses. The salary of the field secretary will not be charged against this account.

The committee also discussed the problem of granting opportunity of postgraduate study in our teaching institutions to foreign students, without the necessity of their procurement of license to practice medicine in Indiana. It was decided to refer the matter to the Council for their consideration.

E. H. CLAUSER, M.D., *Chairman*,
 HARRY E. KLEPINGER, M.D.,
 HARRY P. ROSS, M.D.,
 HERMAN M. BAKER, M.D.,
 O. O. ALEXANDER, M.D.,
 CLEON A. NAFF, M.D.

COMMITTEE ON PUBLIC RELATIONS

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Public Relations of the Indiana State Medical Association has held meetings on January 12, 1949, and June 22, 1949. In formu-

lating its plans, the committee adopted as its central theme that most effective public relations must be at the local level and that each physician must assume his fair share of responsibility for good public relations. The large number of patient contacts daily by Indiana physicians constitute our most important asset and every physician should do his utmost to improve physician-patient relationship.

In order for the physician to be familiar with the activities at national, state and county levels, your committee decided that "I.S.M.A. News Flashes" should be sent monthly to all members of the association. An attempt has been made to include in this bulletin information which will be helpful to the physician in answering patients' questions. It is essential that physicians be well-informed and comments from members of the association have indicated that the bulletins have served a good purpose.

The committee was very ably assisted in its work for four months by Mr. Larry Richardson, field secretary of the Indiana State Medical Association. Mr. Richardson was succeeded by Mr. James A. Waggener on May 15, and Mr. Waggener's services have proved invaluable to the committee.

Your committee has realized the importance of integration of the work of the various committees of the association and has made every effort to correlate its work with other committees. Particularly important in this connection is the close correlation with the work of the A.M.A. Campaign Coordinating Committee. The response to the request of the Committee on Public Relations and subsequently of the A.M.A. Campaign Coordinating Committee, that local societies take measures to insure twenty-four hour medical service, has been most gratifying.

Public Relations Committees have been set up in many of the county societies and there is increasing evidence of activity on the part of these local committees. In many instances speakers' bureaus are being set up at the local level and the request that speakers available locally be recorded in the headquarters office has been very encouraging.

The recommendation of your committee to the Executive Committee that a speakers' bureau be set up at a state level has been implemented and a group of lay speakers of top level caliber is now on file in the headquarters office. These speakers are available for important speaking engagements.

The local units of the Woman's Auxiliary have displayed increased activity and their efforts have been of inestimable value from a public relations standpoint.

Several matters of importance have been referred to the committee. Some of these matters might have been more properly assigned to the Committee on Publicity. The multiplicity of

committees with overlapping duties induces the committee to recommend that the work of the Committee on Publicity and the work on Public Relations be combined.

WEMPLE DODDS, M.D., *Chairman*
 JOHN D. VAN NUYS, M.D.,
 C. A. HARTLEY, M.D.,
 RUSSELL W. LAVENGOOD, M.D.,
 R. W. OLIPHANT, M.D.,
 B. E. EDWARDS, M.D.,
 F. S. CROCKETT, M.D.

AUDITING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Auditing Committee met for its annual meeting on July 27, 1949, at the Indiana National Bank, Indianapolis. Investments of the association were examined and found to be in order in both the General Fund and Medical Defense Fund. With \$41,000 in the General Fund and \$15,000 in the Medical Defense Fund, investments of the association total \$56,000 as of July 31, 1949, as against \$51,000 at this time last year. A detailed list of bonds held by the association is contained in the treasurer's report on pages 952, 953 and 954.

Cash balances in the Indiana National Bank, the American National Bank, the Fletcher Trust Company, and the Bankers Trust Company, as shown by the bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, THE JOURNAL Fund, and the Petty Cash Fund, respectively, and show the following balances as of July 31, 1949:

General Fund	\$39,338.15
Medical Defense Fund	3,087.73
THE JOURNAL Fund	10,622.41
Petty Cash Fund	99.74
	<hr/>
	\$53,148.03

JESSE E. FERRELL, M.D., *Chairman*,
 CLAUDE DOLLENS, M.D.,
 HARRY MURPHY, M.D.

COMMITTEE ON CANCER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Cancer met April 8, 1949, at Indiana University Medical Center, where at that time the second annual two-day post-graduate course on malignant diseases was in progress. The committee was loud in its praise of this very excellent symposium on cancer which brought to Indiana some of the top ranking men in the field, including Dr. C. P. Rhoads, Director of Memorial Hospital and Sloan-Kettering Institute of New York. The committee, however, expressed disappointment in the attendance of practicing physicians and while praising the medical school

and the Indiana Cancer Society for presenting such a fine program they urged that future post-graduate conferences of this caliber be better advertised to the profession.

Discussing further the professional education advantages being provided by the Cancer Society, Dr. Don D. Bowers, chairman of the society's Professional Education Committee, reported that catalogues of recent literature, films and statistical material had been sent to the larger hospital libraries throughout the state and that many of these materials could be borrowed from the Cancer Society headquarters in Indianapolis, including the new film, "Cancer: The Problem of Early Diagnosis."

Doctor Bowers further outlined plans for the possible building of "cancer teaching teams" in cooperation with the medical school that could be available for district, county or staff medical meetings. Also outlined were plans for "teaching kits" including films, slides, statistics, etcetera, that could be loaned to groups to aid in developing local programs.

The committee expressed satisfaction with the progress being made in professional cancer education.

Cancer Clinics

Doctor Bronson reported the probable discontinuation of the cancer detection clinic which has been in operation in downtown Terre Haute for some two years, and anticipated the establishment of a diagnostic clinic in Union Hospital. Doctor Bronson believes that the hospital diagnostic clinic will provide greater and more satisfactory services to the medical profession and the people of his community. The opening of the Allen County Detection Center in Fort Wayne in March provides now the only pure detection clinic, not connected with a hospital, in the state. This clinic is open to the public and is serviced by a group of Allen County physicians. It is housed and sponsored by the Allen County Cancer Society. New diagnostic service centers were reported in Evansville, Crawfordsville, Bluffton, Columbus and Valparaiso. St. Joseph County and Lake County report progress of physicians' cooperation in providing uniform physical examinations and filing histories for review by tumor committees. Lake County contemplates a tumor board in each of its major hospitals.

The Indiana Cancer Society some time ago designated 13 major and 10 minor areas where cancer diagnostic clinics might be established with adequate trained professional personnel either existing or contemplated. It now reports 19 clinics in 13 of these areas, namely:

Evansville—3
 Terre Haute
 Indianapolis—2 (indigent only)
 Crawfordsville
 Lafayette
 Anderson
 Bluffton (Caylor-Nickel Clinic)

New Castle

Fort Wayne (detection only)

South Bend (consultative)

Lake County—4 (consultative)

Valparaiso

Rensselaer

The Cancer Society now has some type of service or educational program in 72 counties. Mostly these consist of loan closets, individual aid in emergencies, and spreading of general education to the public by volunteer workers. In nine of the larger areas, however, these services include a full time secretary who coordinates and implements the program. In all areas there is a close working agreement between the Cancer Society and the County Medical Society.

Research Progress

The gigantic research program of the American Cancer Society now includes some 280 projects in 132 Institutions throughout the country, our own Indiana University being among them. The Indiana Cancer Society, aided by funds raised by Elks Lodges and the Lions Clubs, has sponsored supplementary research and professional education in Indiana in an amount exceeding \$100,000 during the past year. These projects dealing with research were approved by the National Research Council and are not duplications of work going on elsewhere. Chief among these projects are the cytological studies and experimentation at Indiana University Medical School, and basic research at Purdue in testing the reactions of certain drugs and radioactive materials to carcinogenic substances. Other projects deal with virus growth and genetics at Indiana University Bloomington campus, and statistical studies and development at the Medical Center, Ball Memorial Hospital in Muncie, and elsewhere.

Cancer Registry

Last year your committee approved the establishment of a state-wide cancer registry to be developed by the Pathologists Association and the State Board of Health. The Indiana Cancer Society granted \$10,000 to get this program set up. We are able to report that satisfactory progress is being made under the leadership of Dr. Lall G. Montgomery of Muncie and Dr. Wendell Anderson of the State Board of Health. In addition to the gathering and cataloguing of statistics and materials, the services of a technician have been made available to any hospital laboratory in the state for education in new techniques and procedures in the preparation of tissues. The assembled specimens will be reviewed from time to time by members of the Pathologists Association.

While this program will provide the greatest direct educational value to the pathologist, it should eventually help all men dealing with cancer.

Lay Interest Continues

No medical subject has had wider publicity by press, radio and conversation in the past year than

the subject of cancer. Most of this we feel has been helpful in making the public more conscious of the symptoms of cancer and the difficulties affecting its treatment. Cancerphobia is a reality and is aggravated to some extent, to be sure, by this publicity, but your committee feels the good far outweighs the bad in the general education program.

Fund raising was more difficult in 1949 due to economic conditions and to giver's fatigue from so many demands of all kinds. Even so, the total contributions will not be materially less than the two previous years, which brought in slightly in excess of \$300,000. Of this amount, 40 percent is sent to the American Cancer Society, Inc., 40 percent remains in the counties, and 20 percent supports the program of the state society.

In conclusion, your committee wishes to report general satisfaction with progress in cancer control in Indiana, and praiseworthy cooperation by physicians everywhere. We feel that not only is more attention being given to cancer but that excellent public relations are coming from our active support in this popular movement.

CHESTER A. STAYTON, SR., M.D., *Chairman*,

SETH ELLIS, M.D.,

MELL B. WELBORN, M.D.,

P. J. BRONSON, M.D.,

FREDERIC W. TAYLOR, M.D.,

D. C. McCLELLAND, M.D.

COMMITTEE ON CENTENNIAL HISTORY AND PUBLICATIONS

*House of Delegates,**Indiana State Medical Association.*

Gentlemen:

Our committee for the first four years was known as the Committee on Centennial Celebration, but this year it was given the title of Committee on Centennial History and Publications.

The only duties delegated to it in 1949 were those incident to the publication of the History of the Association. This opus was finally completed and was run serially in THE JOURNAL. It will appear in book form on sale during this coming annual session.

We make one final appeal to each county society to place at least one copy of this history in the public libraries of each of the counties of Indiana, where it will always be available for future reference.

CHARLES N. COMBS, M. D., *Chairman*EDGAR F. KISER, M.D., *Vice Chairman*,

A. C. YODER, M.D.,

V. L. TURLEY, M.D.,

J. B. MAPLE, M.D.,

M. C. PITKIN, M.D.,

W. D. GATCH, M.D.,

WILLIAM N. WISHARD, JR., M.D.

COMMITTEE ON CIVIC RELATIONSHIP AND COMMUNITY HEALTH AGENCIES

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Civic Relationship and Community Health Agencies of the Indiana State Medical Association held a meeting on Sunday, April 24, 1949, at the Columbia Club, Indianapolis. Dr. Augustus P. Hauss, president of the state medical association, met with the group. Eighty-five percent of the members were present and the meeting was called to order at 10:30 a.m., and was in session until 3:00 p.m. During this period luncheon was served.

The first committee chairman to report was Dr. Frank G. Sink of Remington. Doctor Sink spent a great deal of time explaining the activity of his committee, which has to do with rural health councils. This committee is entrusted with a great responsibility. Their success can be appreciated when reference is made to the committee's annual report printed in the Handbook.

Dr. Stuart R. Combs, Chairman of the Committee on Heart Disease, reported that the U. S. Public Health Service had attempted to place a special study project on heart diseases in some Indiana city. Several health departments had been offered this opportunity; however, none of them had accepted to date.

Discussion as to the advisability of the type of project was entered into. Dr. J. V. Pace, chairman of the Committee on Tuberculosis, reported on the Mishawaka tuberculosis study.

Dr. Marshall I. Hewitt, chairman of the Committee on Diabetes, reported that his committee was attempting to conduct its own study without outside aid. He stated that the membership of the society would soon receive questionnaires to fill out relative to the subject of diabetes.

Dr. Wemple Dodds reported at length about the activity of his committee relative to publicity and public relations.

Some of the committees had had no meeting and were, therefore, unable to give a report of their activities.

All in all, the meeting called the attention of each committee head to the amount of effort in which other committees were engaging. In many instances the method that the committee was using was enlightening to another committee head. No doubt this will prove stimulating.

Probably the greatest result that will come from the meeting will be the committee's realization of the need of team work with other committees in our association; but, more than this, cooperation with the many private agencies that are carrying out some type of health endeavor.

F. R. NICHOLAS CARTER, M.D., *General Chairman,*
CHESTER A. STAYTON, M.D., *Chairman,*
Committee on Cancer

C. W. RUTHERFORD, M.D., *Chairman,*
Committee on Conservation of Vision
WAYNE R. GLOCK, M.D., *Co-chairman,*
R. R. HIPPENSTEEL, M.D., *Co-chairman,*
Committee on Crippled Children
Services and Infantile Paralysis
MARSHALL I. HEWITT, M.D., *Chairman,*
Committee on Diabetes

DILLON D. GEIGER, M.D., *Chairman,*
Committee on Hard of Hearing
STUART R. COMBS, M.D., *Chairman,*
Committee on Heart Disease
W. U. KENNEDY, M.D., *Chairman,*
Committee on Indigent Medical Care
E. S. JONES, M.D., *Chairman,*
Committee on Industrial Health
NEAL E. BAXTER, M.D., *Chairman,*
Committee on Maternal and Child Health

A. M. DEARMOND, M.D., *Chairman,*
Committee on Mental Health
J. O. RITCHEY, M.D., *Chairman,*
Committee on Publicity
WEMPLE DODDS, M.D., *Chairman,*
Committee on Public Relations
A. F. WEYERBACHER, M.D., *Chairman,*
Committee on Prepaid Medical and Hospital Insurance

FRANK G. SINK, M.D., *Chairman,*
Committee on Rural Health
B. N. LINGEMAN, M.D., *Chairman,*
Committee on School Health and Physical Education
C. V. ROZELLE, M.D., *Chairman,*
Committee on Traffic Safety
JEROME V. PACE, M.D., *Chairman,*
Committee on Tuberculosis
MINOR MILLER, M.D., *Chairman,*
Committee on Venereal Disease
WILLIAM H. GARNER, M.D., *Chairman,*
Committee on Veterans Affairs and Rehabilitation

COMMITTEE ON CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Conference of County Medical Society Officers was held in the Riley Room of the Claypool Hotel, Indianapolis, on Sunday, January 30, 1949. There were 150 doctors who attended the meeting. The name of this conference was changed from the Secretaries' Conference to the Conference of County Medical Society Officers, with all members of the state society welcome to attend all meetings. This conference was to be a workshop of the medical profession in all problems that are not scientific.

Dr. C. S. Black, of Warren, president-elect, opened the meeting with a short welcoming address.

Dr. J. William Wright, of Indianapolis, co-chairman of the Committee on Public Policy and Legislation, gave a report on the activities of his committee in connection with the current session of the legislature.

Dr. Joseph H. Clevenger, of Muncie, read a paper on "Relationship of the County Medical Society and the County Health Council."

Dr. Wemple Dodds, of Crawfordsville, chairman of the Committee on Public Relations, reported on the deliberations of his committee.

Dr. A. P. Hauss, of New Albany, president of the state association, related briefly the history of the conference. Doctor Hauss concluded with a splendid talk on the background for the A.M.A. Educational Campaign, and spoke vigorously in support of the A.M.A. assessment.

Dr. Joseph S. Lawrence, director, Washington Office, American Medical Association, gave an informative talk which described the functions of his office in relation to the national legislative program.

The voluntary prepayment medical care insurance program was discussed, as to its status in Indiana, by Mr. R. S. Saylor, executive vice-president of Mutual Medical Insurance, Inc. The status nationally was reviewed by Mr. Howard Brower, of the Council on Medical Service, American Medical Association.

Dr. J. Neill Garber, Indianapolis, chairman of the Committee on Centennial Arrangements, outlined the plans for the Centennial Convention. He announced the tentative schedule for a four-day convention.

A brief discussion of the policies for THE JOURNAL, as determined by a recent meeting of the Editorial Board, was given by Dr. Frank B. Ramsey, editor.

The meeting was concluded by Mr. Ray E. Smith, executive secretary of the association, who discussed the actions taken at the midwinter meeting of the Council.

The last order of business was the unanimous election of Dr. A. M. Mitchell, Terre Haute, as the chairman of the conference for 1950.

Also see the report in THE JOURNAL of the Indiana State Medical Association, page 235, March 1949.

ALBERT M. MITCHELL, M.D., *Chairman*
 GLEN W. LEE, M.D.,
 KENNETH OLSON, M.D.,
 JOHN P. SCHERSCHER, M.D.,
 THOMAS M. CONLEY, M.D.,
 FRANK W. MESSER, M.D.

COMMITTEE ON CONSERVATION OF VISION

*House of Delegates,
 Indiana State Medical Association.*

Gentlemen:

The chairman of this committee attended the all-day session of the Committee on Civic Relationship and Community Health Agencies of the I.S.M.A. on April 24, 1949.

Our committee sponsored the Conservation of Vision breakfast at the time of the state association meeting. Otherwise this committee has been inactive in the current year because no problem nor project has been brought up for our consideration.

There is ample evidence that the incidence of blindness is declining in Indiana. An important factor in this economic advancement is the effective work of many other committees whose functions are concerned with the prevention and control of those diseases which have been responsible for much blindness in the past, and with the reduction of physical hazards that have so frequently lead to loss of sight.

C. W. RUTHERFORD, M.D., *Chairman*,
 CARL J. RUDOLPH, M.D.,
 RICHARD P. GOOD, M.D.,
 WILLIAM M. COCKRUM, M.D.,
 ROBERT A. SMITH, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

*House of Delegates,
 Indiana State Medical Association.*

Gentlemen:

The Committee on Constitution and By-Laws had nothing referred to it during the year, hence the members did not hold a meeting. We wish to call attention, however, to the fact that the Constitution and By-Laws, as recodified by this committee in 1948, will come before the House of Delegates for final acceptance this year.

In accordance with Article XIV of the Constitution which specifies that "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association," the Constitution, containing the changes recommended by the 1948 Reference Committee on Amendments to the Constitution and By-Laws and accepted by the House of Delegates last year, was printed in the August issue of THE JOURNAL and is reprinted as a part of this report. Words, phrases, sentences, or paragraphs of the Constitution which are to be replaced or abolished are inclosed in parentheses, while the newly accepted amendments are printed in bold face type.

CONSTITUTION OF THE INDIANA STATE MEDICAL ASSOCIATION

ARTICLE I—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the (entire) medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of (state medicine,) **medical care**, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV—COMPOSITION OF THE ASSOCIATION

(Section 1.—This Association shall consist of Members, Delegates, Guests, and Associate and Honorary Members.)

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members, and Honorary Members.

(Sec. 2.—*Members*—The members of this Association shall be the members of the component county medical societies. Membership in a county medical society on a basis not including membership in the Indiana State Medical Association is not recognized.)

Sec. 2.—Active Members—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant membership therein on a basis that does not include membership in the Indiana State Medical Association.

(Sec. 3.—*Delegates*.—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.)

—Sec. 3, above, is to be omitted. The present Sec. 4, therefore, will become Sec. 3.—

Sec. 3.—Associate Members—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

(Sec. 5.—*Honorary Members*—Honorary members shall consist of representative teachers and students of science allied to medicine and of physicians and surgeons of distinction not members of the Indiana State Medical Association, who may by vote of the House of Delegates be elected to honorary membership; and any physician of the State of Indiana who has attained the age of seventy-five years and has held membership in the Indiana State Medical Association for twenty years or more may be elected to honorary membership by vote of the House of Delegates, provided his name be proposed for such honorary membership by the county medical society of which such physician is a member.)

Sec. 4.—Senior Members—Senior members shall be physicians of the State of Indiana who have attained

the age of seventy-five years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—Honorary Members—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

(Sec. 6.—*Guests*.—Any distinguished physician not a resident of this state who is a member of his own State Association may become a guest during any Annual Session on invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that session.)

Sec. 6.—Rights and Privileges of Members.—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive "The Journal" of the State Association, they shall pay the regular subscription fees therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be **ex officio members**: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, (Executive Secretary), and Treasurer. Besides its duties mentioned in the By-Laws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-Laws, and at all times shall be the finance committee of the Association. (Five) **Seven Councilors** shall constitute a quorum.

(ARTICLE VII—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be com-

posed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

(ARTICLE VIII—SESSIONS AND MEETINGS)

(Section 1.—The Association shall hold an Annual Session during which there shall be held daily general meetings and such section meetings as may be provided for, all of which shall be open to all registered members and guests.)

ARTICLE VIII—CONVENTIONS AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

(Sec. 2.—The time and place for holding each Annual Session shall be fixed by the House of Delegates at the preceding Annual Session.)

Sec. 2.—The House of Delegates shall select the place for two years in advance for holding the annual conventions. The time for the conventions shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special (sessions) meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. All of these officers shall serve until their successors are elected and installed. **Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with section 4 of this article.**

Sec. 3.—The officers of this Association **with the exception of the Executive Secretary** shall be elected by the House of Delegates (on the morning) **as the first order of business** of the last day of the Annual (Session) Convention, and no person shall be elected to any such office who is not in attendance on that Annual (Session) Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each councilor district shall elect an alternate councilor whose term of office shall be the same as the councilor, namely three years. The alternate councilor shall be elected in a year during which there is no councilor elected.

The duties of the alternate councilor shall be:

1. To represent the council district in the absence of the regularly elected councilor.

2. To vote only in the absence of the regularly elected councilor either in the House of Delegates or in Council meetings where he represents the regularly elected councilor.

3. The alternate councilor shall not have the power of discussion if the regularly elected councilor is present, but he shall attend all meetings of the Council, unless he has a reasonable excuse for not doing so.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become president pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

(ARTICLE XI—FUNDS AND EXPENSES)

(Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds also may be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publication, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.)

ARTICLE XI—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual (Session) Convention, provided that such amendment shall have been presented in open meeting at the previous Annual (Session) Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

The House of Delegates accepted the recommendation of the 1948 Reference Committee on Amendments to the Constitution and By-Laws "that final vote on the revision of the Constitution and By-Laws be included in the order of business in the next annual convention." Since the By-Laws were approved by the House of Delegates last year, the sections abolished by that action have been deleted from the following copy. Words, phrases, sentences, paragraphs or sections adopted last year are printed in bold face type.

BY-LAWS

CHAPTER I—MEMBERSHIP

Section 1.—The term "Member" as used in these By-Laws unless otherwise indicated shall mean both active and senior members.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that Convention. No member shall take part in any of the proceedings of an annual Convention until he has complied with the provisions of this section.

CHAPTER II—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President shall be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for each annual convention, for the entertainment of its members and guests, such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such convention. The entertainment funds so appropriated shall be expended at the direction of the Committee on Convention Arrangements, appointed by the president for the convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the State Association.

CHAPTER III—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the General Meetings may hold the following Section Meetings:

- a. Surgical.
- b. Medical.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. General Practice.
- f. Obstetrics and Gynecology.

g. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV—HOUSE OF DELEGATES

Section 1.—The House of Delegates shall meet the day before or during that fixed as the first day of the scientific meeting of the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one Delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and By-Laws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate to be selected by the physicians residing in such county.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before August first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5.—Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the Reference Committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

CHAPTER V—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The terms of offices shall be for the calendar year following the date of election.

CHAPTER VI—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all General Meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. He shall pay money out of the treasury only on a written order by the President, countersigned by the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's Headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the Committees, the Council, and the Officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expense of attending the Annual Convention.

CHAPTER VII—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may re-

quire, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman; and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates.

Sec. 2.—Each Councilor shall be organizer, peace-maker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. **The House of Delegates may take such action, if any, as it deems appropriate upon such reports.** The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates

or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall elect two members of the Association, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee.

CHAPTER VIII.—STANDING COMMITTEES

Section 1.—The standing committees shall be as follows:

The Executive Committee.

A Committee on Convention Arrangements.

A Committee on Scientific Work.

A Committee on Scientific Exhibits.

A Committee on Public Policy and Legislation.

A Committee on Publicity.

A Committee on Industrial Health.

A Committee on Medical Education and Hospitals.

A Committee on Public Relations.

A Committee on Constitution and By-Laws.

Such committees, except the Executive Committee, which is elected by the Council, shall be appointed by the President of the Association.

All members of Committees shall serve for one year unless otherwise specified in these By-Laws or in the authorization for appointment.

Sec. 2.—The Executive Committee, consisting of six members as heretofore provided for, shall meet on the call of the chairman or of any three members with the Executive Secretary to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall constitute the Medical Defense Committee of the Association and shall have full authority governing all matters pertaining to the medical defense features of this Association, and shall be governed by the rules and regulations concerning such features as provided for in the By-Laws of this Association. It shall represent the Council during intervals between meetings of that body, including matters pertaining to the Journal of the Association, and shall report its doings to the Council.

It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and By-Laws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and By-Laws shall be incurred by any officer or committee. A committee or an officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Sec. 3.—*The Committee on Convention Arrangements shall consist of five or more members.* With the advice and assistance of the Executive Secretary this Committee shall provide suitable accommodations for the meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and commercial exhibits, and in conjunction with the Executive Secretary shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements for and the character of any and all commercial exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 4.—*The Committee on Scientific Work shall consist of three or more appointive members appointed annually by the President; and of the Chairman of the Committee on Scientific Exhibits and of the Chairman of the sections as Ex-Officio members.* It shall be the duty of the officers of the various sections to prepare and submit to this committee prior to the first meeting of the committee a suggested program of subjects and personnel for their respective sections in the Annual Convention. The scientific program and the financial requirements to provide for it must be approved by the Executive Committee before the program is officially announced.

Sec. 5.—*The Committee on Scientific Exhibits shall consist of five or more appointive members.* It shall have the duty of arranging for Scientific Exhibits as a part of the Annual Conventions, subject to the approval of the Executive Committee.

Sec. 6.—*The Committee on Public Policy and Legislation shall consist of at least five or more appointive members.* Under direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of public health, medical education, scientific medicine, and the improvement of the medical profession. It shall keep in touch with professional and public opinion and shall endeavor to create and direct public opinion to the end that the public will demand adequate legislation for the promotion of the public good in relation to medicine and the enforcement of such legislation.

Sec. 7.—*The Committee on Publicity shall consist of three appointive members.* It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, and for addresses or talks delivered before lay audiences under the authority of the Association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.

Sec. 8.—*The Committee on Industrial Health shall consist of five or more appointive members.* The duties of the committee shall be: To study and gather facts and become intimately acquainted with the problems regarding industrial health, including any such problems as those relating to the prevention and cure of industrial injuries and diseases; to the method and means of providing adequate medical and hospital care for those suffering from industrial diseases and injuries; and to the maintenance of cooperation and mutual understanding among the members of the medical profession, employers of labor, employees and insurance carriers.

Sec. 9.—*The Committee on Medical Education and Hospitals shall consist of five appointive members.* The duties of this committee shall be to cooperate with the authorities of the Indiana University School of Medicine in efforts to improve the educational standards of the state as they pertain to the practice of

medicine; to act in conjunction with the members of the Council in providing postgraduate clinics or teaching for the various Councilor medical districts of the state; to cooperate with the Hospital Council of the Indiana State Board of Health in connection with the making and recommending of rules and regulations for the management of hospitals; to select one of its own members as a delegate to the yearly Conference on Medical Education and Hospitals of the American Medical Association; and to cooperate with the corresponding Council of the American Medical Association.

Sec. 10.—*The Committee on Public Relations shall consist of five or more appointive members.* The duties of the committee shall be to continuously develop and carry on a program to improve and sustain good will among the members of the medical profession and the general public; to study and assemble information regarding the means by which the interests of the public relations of the medical profession may best be served; to obtain through public and professional contacts and report to the profession through proper means information regarding the sentiments, criticisms and suggestions for improvement which may be made either by members of the profession or by the lay public; and to have the special responsibility of furnishing leadership and guidance in keeping the medical profession as a whole within the deserved respect and esteem of the people.

Sec. 11.—*The Committee on Constitution and By-Laws shall consist of five appointive members.* The duties of this committee shall be: to keep in contact with the developments and changes in procedures in carrying on the work of this Association; to suggest revisions necessary to keep the Constitution and By-Laws always in accord with the practices and procedures best adapted to the functioning of the Association; and to keep the practices and procedures consistent with the provisions from time to time contained in the Constitution and By-Laws—to the end that all members of the profession, by reference to the Constitution and By-Laws, may be able to obtain accurate information regarding procedure and practices within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and By-Laws may be avoided.

Sec. 12.—*The President and Executive Secretary shall be ex officio members of all the foregoing standing committees where their inclusion on the committee is not otherwise provided for in these By-Laws.*

CHAPTER IX.—SPECIAL COMMITTEES

The President may appoint such other committees in addition to the Standing Committees as he deems necessary or as may be specially authorized by The House of Delegates, The Council, or The Executive Committee. Any such committees shall be known as Special Committees.

CHAPTER X.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of The Reference Committees to serve during the Convention for which they are appointed. Appointments to these Reference Committees, the members of which serve during the Convention for which they are appointed, shall be made by the President in time for them to be published in THE JOURNAL and THE Handbook prior to such Annual Convention.

The president shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these

committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following reference committees are hereby constituted:

(1) A Committee on Sections and Section Work to which shall be referred all matters relating to the sections or section work.

(2) A Committee on Rules and Order of Business to which shall be referred all matters regarding rules governing the action, methods of procedure, and order of business of the House of Delegates.

(3) A Committee on Medical Education and Hospitals to which shall be referred all matters relating to medical education and medical colleges and hospitals.

(4) A Committee on Public Policy and Legislation to which shall be referred all matters relating to state and national legislation, and memorials to the legislature, to the United States Congress, to the Governor of the state, or to the President of the United States.

(5) A Committee on Publicity to which shall be referred all matters relating to publicity.

(6) A Committee on Hygiene and Public Health to which shall be referred all matters relating to hygiene and public health.

(7) A Committee on Amendments to the Constitution and By-Laws to which shall be referred all proposed amendments to the Constitution and By-Laws.

(8) A Committee on Reports of Officers to which shall be referred the address of the President and the reports of the Executive Secretary, Treasurer, and the Council.

(9) A Committee on Credentials to which shall be referred all questions regarding registration and the credentials of delegates.

(10) A Committee on Miscellaneous Business to which shall be referred all business not otherwise disposed of.

Sec. 3.—The time and place of meetings of all Reference Committees shall be publicly posted, and all meetings of all Reference Committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to Reference Committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and By-Laws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are

in conflict with the letter and spirit of this Constitution and By-Laws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any charges in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in offices, and personnel of membership. A copy of this quarterly report to the councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each County Society Secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and payable in advance. The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members. The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. **Provided, however, that beginning January 1, 1948, physicians elected to their first membership in this association during the first nine months of any year shall pay as dues for the remainder of that year the sum of \$15.00; and those elected to membership after October 1st of any year shall pay \$5.00 as dues for the remainder of that year.**

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and By-Laws, not in conflict with the Constitution and By-Laws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER XII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XIII.—MEDICAL DEFENSE

Section 1.—Seventy-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Committee on Defense of the Association.

Sec. 3.—This committee shall have full authority governing all matters pertaining to the Medical Defense features of this Association: with power to

enter into agreement for the payment of fees of one attorney whom the physician sued shall have the right to choose, provided such attorney is of good reputation and standing at the bar, and to employ expert witnesses and incur such other expenses as in the judgment of the committee may be necessary in the defense of members against whom suits may be brought; provided, always, that the total expenditure in any single suit shall not exceed 25 per cent of the fund available at the time suit is filed; and provided further that this Association shall not be liable for attorney's fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. **Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and countersigned by the President and the Chairman of the Council.**

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Committee on Medical Defense in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Committee on Medical Defense of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Committee on Medical Defense of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Committee on Medical Defense shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these By-Laws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XIV.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XV.—AMENDMENTS

Section 1.—These By-Laws may be amended at any Annual Convention by a majority vote of all the delegates present at that Convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and By-Laws all previous Constitutions and By-Laws are hereby repealed.

The Committee on Constitution and By-Laws recommends the adoption of this Constitution and By-Laws.

I. C. BARCLAY, M.D., *Chairman*,
GORDON A. THOMAS, M.D.,
A. W. CAVINS, M.D.,
CLAUDE D. HOLMES, M.D.,
JOSEPH LANG, M.D.,
W. DONALD CLOSE, M.D.

COMMITTEE ON CRIPPLED CHILDREN SERVICES AND INFANTILE PARALYSIS

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

A meeting of the Joint Committee on Crippled Children Services and Infantile Paralysis was held at the Athenaeum, Indianapolis, on August 2, 1949. Those present were Augustus P. Hauss, M.D., president of the Indiana State Medical Association; L. E. Burney, M.D., State Health Commissioner, and the following members of the Joint Committee:

R. R. Hippensteel, M.D., Indianapolis
Wayne R. Glock, M.D., Fort Wayne
Co-chairmen,

Joseph C. Lawrence, M.D., Evansville
James W. Baxter, Jr., M.D., New Albany
Irvin E. Huckleberry, M.D., Salem
James M. Leffel, M.D., Indianapolis
Naomi L. Dalton, M.D., Bloomington
Elton R. Clarke, M.D., Kokomo
Gilbert T. Hyatt, M.D., Evansville

The meeting was called to order by Dr. Hippensteel at 7:00 p.m., who made the motion that Dr. Glock be elected chairman of the Joint Committee for this special meeting. This motion was voted upon and carried.

The purpose of this meeting was to review the polio situation in the state of Indiana which seemed to be critical at this time.

Dr. Hauss was called upon and made very timely and constructive remarks regarding the urgent need to review the present situation concerning the high incidence of poliomyelitis in the state of Indiana.

Dr. Hippensteel discussed the disadvantages of having combined the two committees, namely the Committee on Crippled Children Services and the Committee on Infantile Paralysis, because there is very little relationship between these two committees. It has made the function of each committee difficult. Dr. Hippensteel stated that there have been many local meetings in Indianapolis and surrounding areas concerning the present poliomyelitis epidemic. There was a generalized discussion of all members present as regards various meetings held in other localities in the state.

Dr. Clarke stated that there should be some provision made each year to anticipate the needs in caring for the peak polio load. The facilities of local hospitals in caring for acutely ill and paralytic cases were discussed by Dr. Lawrence and Dr. Leffel. It was brought out that many people throughout the state feel that they want to come to the Riley Hospital or Indiana University Medical Center, thus increasing the patient load in Indianapolis. There was a generalized discussion of the advisability of taking care of polio patients in local hospitals. It was brought out by Dr. Burney that there are twenty-four hospitals throughout the state which have facilities for taking care of communicable disease at this time.

There was a discussion of acute polio being cared for in a contagious unit in any hospital. It seems to be desirous to have the facilities for isolation technique and to develop personnel to carry out treatment during such periods of high incidence of the disease. There seems to be some need of further education of the general public that poliomyelitis cases do not endanger other patients with proper isolation technique. Hospital administrators could be of great help with physical arrangements for isolation units in the local communities. The State Board of Health suggested that cases be held locally wherever possible, and that it would help with suggestions as to management of the situation with the facilities at hand. The State Board of

Health also offered to aid in obtaining personnel and equipment.

At this present time there are 235 recorded cases to date with 26 deaths up to August 2, 1949.

Dr. Burney gave a detailed report from the first meeting of the Indiana Polio Committee which was held on July 20, 1949. There have been two teams in the field from the State Board of Health to assist the local health officers. It was brought out that fly control would not prevent an epidemic but that fogging is a help and that the State Board of Health recommended a thorough sanitation program. Fogging alone, although of some benefit, may give a false sense of security. It was brought out that elective surgery in children should be deferred during the polio season. It was the consensus that the radio and newspaper publicity was adequate in most communities but that further educational program should be carried out. Bulletins will be distributed frequently with latest pertinent information to members of the Indiana Polio Committee, hospitals and health officers.

There was a general discussion of Dr. Burney's report and of the State Board of Health program in detail. The present polio epidemic is being handled capably and efficiently as is possible. There was complete accord with policies and management of the State Board of Health.

A motion was made by Dr. Hyatt that we accept and endorse the report given by Dr. Burney and the State Board of Health program. This was seconded by Dr. Hippensteel, voted upon and unanimously carried.

The chairman named Dr. Leffel and Dr. Hippensteel as members of a sub-committee to act in liaison capacity with the Indiana Hospital Association. Dr. Leffel made the motion that we should go on record that we may have a possible serious shortage of beds for polio patients, that this situation should be recognized by the hospitals throughout the state and all preparations should be made to handle an increased case load. This was seconded by Dr. Clarke. This was voted upon and carried.

Dr. Hippensteel moved that we recommend to the House of Delegates that the two committees, the Committee on Crippled Children Services and the Committee on Infantile Paralysis, be separated. This was voted upon and carried.

Dr. Burney brought up the problem of the advisability of holding the State Fair this year. After considerable discussion Dr. Leffel made the motion that if the acute cases of poliomyelitis continue with a high incidence that the State Fair be discontinued at the discretion of the State Board of Health. This was seconded by Dr. Dalton, voted upon and carried.

Dr. Hauss was called upon for his comments at the conclusion of the meeting which was adjourned at 9:00 p.m.

WAYNE R. GLOCK, M.D.,
R. R. HIPPENSTEEL, M.D.,
Co-chairmen,

ROY SHANKS, M.D.,
JOSEPH C. LAWRENCE, M.D.,
JAMES W. BAXTER, JR., M.D.,
IRVIN E. HUCKLEBERRY, M.D.,
JAMES M. LEFFEL, M.D.,
NAOMI L. DALTON, M.D.,
ELTON R. CLARKE, M.D.,
GILBERT T. HYATT, M.D.

COMMITTEE ON DIABETES

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Diabetes of the Indiana State Medical Association hereby submits its report.

The committee held meetings on January 23, 1949, and on February 6, 1949, at Indianapolis.

At these two meetings lengthy discussions were held which laid the groundwork for the committee's ultimately submitting to the physicians of Indiana a proposed diabetes survey, to be undertaken in October 1949. Copies of this proposal were distributed as follows: one each to the president and secretary of each county society, one to the president of the Indiana State Medical Association, one to the executive secretary of the state association, one to Dr. Franklin B. Peck of Indianapolis, one to the Indiana State Board of Health, one to Dr. Howard F. Root, the chairman of the National Diabetes Detection Drive, one to Dr. William Gambill, chairman of the State Diabetes Detection Drive, and one to Dr. John A. Reed, secretary of the American Diabetes Association.

Response to this proposal has already been gratifying and the Committee on Diabetes earnestly hopes that the physicians of the State of Indiana will support this tremendous project.

MARSHALL I. HEWITT, M.D., *Chairman,*
SAMUEL L. ADAIR, M.D.,
STANTON L. BRYAN, M.D.,
BARUCH M. EDLAVITCH, M.D.,
RUSSELL A. FLACK, M.D.,
LAURA HARE, M.D.,
HERBERT SLOAN, M.D.

COMMITTEE ON HARD OF HEARING

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

A COORDINATED PROGRAM OF HEARING
CONSERVATION AND REHABILITATION

Hearing conservation begins with adult education which may be divided into two parts:

(1) General information regarding hearing health which is to be disseminated to parents, school children, family physicians, nurses and teach-

ers. This is primarily designed as a hearing conservation program.

- (2) Specific information which is to be given to adults as to the means of locating hearing handicapped individuals and dealing with their problems. This is primarily a hearing rehabilitation program.

Present Achievements:

Regarding Conservation—This area has received little attention.

- (1) Private organizations, such as Leagues for the Hard of Hearing and Societies for Crippled Children, contact some people directly through interviews and lectures in order to disseminate information regarding conservation.
- (2) The four state institutions of higher learning do some of the same work through their educational programs.

Regarding Hearing Rehabilitation—More progress has been made in this area, but we are still woefully deficient.

- (1) The state has more specialists who are interested in ear pathology and more general practitioners have become better informed on the subject.
- (2) A state school law requires annual audiometric examinations for all school children, referral of all who are found deficient to physicians, and educational rehabilitation for those who are unable to learn because of their hearing loss. (This law is not enforced and not enough money is available to carry out the program.)
- (3) The Deaf School is available for severely deafened children of school age.
- (4) The Indiana University Medical School has established for hard of hearing and deaf persons an outpatient service which renders medical diagnosis and treatment through the Ear Clinic and educational rehabilitation through the Speech Clinic.
- (5) The four state educational institutions do examinations for educational rehabilitation of the hard of hearing and offer therapy for a limited number of children and adults. These institutions have also offered audiometric tests through their traveling clinics.

Deficiencies of the present program are:

- (1) Little is done in the form of hearing conservation.
- (2) Not enough time is devoted to locating the hard of hearing or deaf pre-school children.
- (3) Those pre-school children who are known to be hard of hearing or deaf have extremely limited programs of medical care and educational rehabilitation.
- (4) The decisions as to where the hard of hearing or deaf child may receive his best education are too often a hit-and-miss proposition.
- (5) The language training facilities in the State School for the Deaf, in terms of equipment, personnel, and building space, are quite inadequate.
- (6) Not enough stress is placed upon the methods of training in public school special classes and in the School for the Deaf which will enable children who are hard of hearing or deaf to be more readily assimilated in the normal public school classes.
- (7) Not enough attention is devoted to the proper evaluation of hearing aids before they are purchased by hard of hearing individuals. The following program is designed to correct some of the deficiencies:

It is with the strongest recommendation of the present Committee on Hearing Conservation that the state medical association move to establish a joint committee which would include representatives from the medical association, the Speech and Hearing Therapy Association, the State Department of Education, and private charitable organizations. The primary purpose of such a committee would be to coordinate and develop a hearing conservation and rehabilitation program in the state of Indiana. The hearing conservation committee made the initial step by calling together representatives of these various areas in a meeting which was held on June 26 in the Columbia Club. The recommendations of this joint committee were that the following matters be studied and acted upon:

- (1) That a joint committee be formed which would function every year.
- (2) That information regarding hearing conservation be sent to the public and to practicing physicians. This information could be presented through the mediums of radio, television, newspapers, professional journals, interviews, and personal letters.
- (3) Coordinate all hearing re-education programs in the state in order to insure the best medical attention and re-education for the hard of hearing and deaf. A further function of this committee would be the dissemination of acceptable information to the lay parents who have hard of hearing children or adults in the family.
- (4) The re-assessment by such a committee of the present laws involving the medical and educational examination and training of hard of hearing or deaf children in order to give the best information and care for the smallest amount of money.
- (5) Further development of the center at Riley Hospital for the pre-school hard of hearing or deaf children, where medical diagnosis and treatment can be offered and re-education methods can be recommended to the parents whose children are in need of the development of language skills. This program should be available for children ranging in age from one

to five years. This program would guide the parents in the language training given to the child in the home.

- (6) The development of more adequate language training for some pre-school hard of hearing children who cannot be trained successfully at Riley on an outpatient basis. In order to facilitate this project, a building program should be recommended for the State School for the Deaf and for the four educational clinics in the state in order to enable them to give residence training for a limited number of pre-school children.
- (7) The state medical association should disseminate more information to general practicing physicians regarding audiometric examinations and hearing care.
- (8) To create centers for hearing aid evaluations to which physicians can refer hearing handicapped persons who need hearing aids.
- (9) To provide more money for special education in order that more of the hard of hearing school children may receive adequate audiometric examinations and hearing therapy.

DILLON D. GEIGER, M.D., *Chairman*

GUY A. OWSLEY, M.D.,

KENNETH L. SHAFFER, M.D.,

SAMUEL M. BAXTER, M.D.,

G. W. SEWARD, M.D.

COMMITTEE ON HEART DISEASE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

A call meeting of the Committee on Heart Disease was held in the headquarters office of the Indiana State Medical Association at 2:00 p.m., Wednesday, June 1, 1949. The members attending were: Morris E. Thomas, M.D., Indianapolis; Don J. Wolfram, M.D., Indianapolis; Robert B. Sander-son, M.D., South Bend; Walter S. Fisher, M.D., Columbus; A. N. Ferguson, M.D., Fort Wayne, and Stuart R. Combs, M.D., Terre Haute, chairman.

The committee met with a member of the United States Public Health Service, Ruth Dunham, M.D.; and George Brothier, M.D., and W. C. Anderson, M.D., of the Indiana State Board of Health.

The meeting was called to order by Doctor Combs, and the member of the U. S. Public Health Service was asked to review the proposed study of heart disease to be carried on in this state. It was brought out that several communities had been contacted regarding the proposed study, and in each instance the local medical society had voted against the request. Following a lengthy discussion of the methods to be employed, the objectives to be obtained, and the personnel involved in the study, the members representing the Public Health Service adjourned.

The committee reviewed these proposed plans and agreed that the objectives were in no way

objectionable, but were rather indefinite. This committee favors a study of the methods available for discovering, treating, and rehabilitation of heart disease patients. It further feels that this study should be carried out in a community having a full time health officer. Finally, it was unanimously agreed by the members of the committee present that the local medical society elect the group to carry out the study and that this group determine the scope of the study to be carried out.

There being no further business, the committee adjourned.

STUART R. COMBS, M.D., *Chairman*

MARTIN B. STRANGE, M.D., (deceased)

ROBERT B. SANDERSON, M.D.

A. N. FERGUSON, M.D.

DON J. WOLFRAM, M.D.

MORRIS E. THOMAS, M.D.

WALTER S. FISHER, M.D.

GEORGE M. COOK, M.D.

C. J. CLARK, M.D.

COMMITTEE ON HISTORICAL EXHIBITS

See special article on page 916.

INDIANA A.M.A. CAMPAIGN COORDINATING COMMITTEE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Following action of the Executive Committee on March 13, 1949, establishing the Indiana A.M.A. Campaign Coordinating Committee, and appointment of committee members by President Hauss, this group met and organized to carry out the responsibilities placed upon it.

Basically, all of our plans and efforts have had the objective of demonstrating the merits of the present system of medical care to the public, as compared to socialized medical plans in other countries, and of convincing our legislators through them that the voluntary way is the American way and that the compulsory way is the socialistic way.

In order to accomplish this objective your committee is attempting to follow the plan of campaign as outlined by Whitaker and Baxter, who are directing the educational campaign for the A.M.A., with several additions which we feel are conducive to a well-rounded program within our state.

In our organization meeting we set forth the following objectives:

1. That the medical profession continue to improve its public relations by:
 - a. Providing round-the-clock medical services.
 - b. Eliminating the infrequent unreasonable

charges of a few of its members, and eradicating all unethical practices.

- c. Initiating better public health services, and more adequate medical care for the indigent, the mentally afflicted, et cetera.
 - d. Increasing medical and hospital and other health facilities where they are needed.
2. That medical and hospital insurance be made available to as great a number of our people as possible by voluntary methods.
3. Distribute literature prepared by the A.M.A. to all doctors for redistribution to their patients; also materials prepared at the state level. That the distribution of these materials also be made through other sources.

4. Establish and maintain an effective speakers' bureau.

5. Use every effective means for publicity and advertising.

6. Secure the passage of resolutions by both state and national convention groups.

7. Prepare radio transcriptions for distribution to county medical societies.

8. Encourage business and professional groups opposed to the socialistic trend in government to join in the fight against compulsory sickness insurance.

Report of our activities, as of July 15, and accomplishments follows:

1. The public relations of the profession have been improved through the splendid cooperation of other committees of the association.

- a. The Publicity Committee conducted a survey and found that 84 counties had established round-the-clock medical service.
- b. Evidence that the medical profession is conscious of its responsibility of eliminating unreasonable charges and unethical practices has accumulated, in the fact that very few complaints are now being received by the state association.
- c. In other committee reports you will note much activity in the field of providing better public health services, et cetera.
- d. The various component societies have been active in establishing adequate health facilities in needed areas throughout the state.

2. Individual physicians and county medical societies have been increasingly active in the advancement of the voluntary prepayment insurance plans. The growth of our own Blue Shield Plan has been impressive, but we hope to see its growth greatly increased during the coming months.

3. The distribution of pamphlets and other materials has been a tremendous task and an expensive one. As of July 15, we have distributed through the state headquarters a total of 407,181 pamphlets, 10,000 stickers and one hundred large size pictures of "The Doctor." This does not take into consideration the materials that have been sent throughout the state direct from the Chicago campaign headquarters. In addition, most of the

doctors have requested copies of the poster, "The Doctor," for display in their offices. Your committee offered the large posters to the hospitals and today most hospitals are displaying these in their waiting rooms.

4. The speakers' bureau is just now reaching effective operation. Early in the effort of this committee we requested each component society to supply the state office with names of persons within its community who would be willing to speak. At this date we have received reports from nine component societies who have sent us 26 names. We hope that during the coming months all county societies will have supplied us with speakers' names.

On the state level we have secured the services of such outstanding persons as Wray E. Fleming, counsel for the Hoosier State Press Association; C. Walter McCarty, general manager of *The Indianapolis News*; Richard T. James, treasurer, Butler University; Clarence A. Jackson, executive vice-president, Indiana State Chamber of Commerce; Eugene Pulliam, publisher of *The Indianapolis Star and News*, and Mrs. Eugene Pulliam.

From the headquarters office we have Albert Stump, Ray E. Smith, Larry Richardson, Joseph E. Palmer and James A. Waggener. We have made arrangements to catalog all organizations in the state, and it is possible that we will have the use of several statewide organizations' mailing lists for the purpose of contacting these groups for securing speakers' time and the passage of resolutions.

5. While no regular schedule of releases pertaining to the campaign activities is in operation, a speaker appearing before a group and the action on a resolution make their own news.

The committee is planning the preparation of advertising materials and suggested copy for use by those county societies that might desire to use advertising, both newspaper and radio, in their local communities.

6. Your committee has been most active in the securing of resolutions from various groups. In fact, as of July 15, Indiana ranked among the top five states in the nation in this activity. It is impossible for us to give an accurate count, due to the fact that there have been many resolutions secured by county medical societies and a great number of these have not been reported to headquarters office. We have secured and forwarded to Chicago forty-eight resolutions, and the outlook for greatly increasing this number in the coming months is exceptionally good. We have been helpful in the adoption of resolutions by ten national organizations.

In addition to the resolutions, the individual physician has done a most effective piece of work in getting his patients to write their congressmen asking that they oppose this legislation. We were told by one Senator that his mail (opposing compulsory health insurance legislation), averaged three thousand pieces a week, with his heaviest single day amounting to nearly five thousand

pieces. This has meant a tremendous job on the part of our representatives in Congress, as they feel obligated to answer each individual letter or card.

7. Your committee surveyed the component societies to determine if there was sufficient interest on their part to justify the expense of preparing radio transcriptions. We failed to find sufficient interest; therefore this part of our program has been laid aside for the present. We are making available to those societies who desire radio materials those programs which have been prepared by the A.M.A.

8. Your committee is very happy to report the splendid cooperation and some financial support of allied business organizations in our campaign activities. The Blue Shield Plan has assumed a portion of our campaign activities. The Indiana Pharmaceutical Association, at its convention, voted to assist in every way possible, and today it is distributing pamphlets and displaying posters in the drug stores throughout the state. We could enumerate many other things that various organizations are doing to assist in this effort of the profession.

Organization of the county society committees has been slow, but we are certain that by this time next year we shall be in a position to report that Indiana heads the list of her sister states in carrying out its part of the overall program.

This committee wishes to re-emphasize that this task is one in which every physician and the many friends of our way of life must play a part. This is a crusade against socialism and statism. It is an all-year-round campaign.

The success so far attained in this program is the result of fine teamwork by our many physicians and well-organized, hard-working headquarters staff.

CLEON A. NAFE, M.D., *Chairman*,
C. H. McCASKEY, M.D.,
W. L. PORTEUS, M.D.,
WEMPLE DODDS, M.D.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Indiana Inter-Professional Health Council met October 13, 1948, with each of the associated groups well represented.

Chairman, Dr. Glen Jenkins called on Dr. Leroy Burney for a report on the progress in the program for the codification of our Indiana health laws.

Mrs. Robert F. Shanks, chairman of the Indiana Advisory Health Council, reviewed proposed legislation intended to assist it in the development and maintenance of local public health units. Dr. Thurman B. Rice further emphasized the need for a better health program in Indiana. He expressed desire for the establishment of a school

of public health at Indiana University and a school of veterinary medicine at Purdue University.

The proposed bill concerning the examination and registration of both professional and practical nurses was reviewed by Miss Winkler, representing the Nurses' Association.

Dr. E. E. Ewbank, representing the Dental Association, discussed proposed changes in the state dental law providing a change in annual registration fees and stricter control over the practice of dentistry.

Mr. Ray E. Smith discussed a proposed bill that would limit the use of the prefix "Doctor."

Considerable discussion followed regarding the advisability of establishing local inter-professional health councils. No action was taken.

E. H. CLAUSER, M.D., *Chairman*,
WILLIAM C. REED, M.D.
AUGUSTUS P. HAUSS, M.D., *Ex-officio*,
ALFRED ELLISON, M.D.,
J. WILLIAM WRIGHT, M.D.

COMMITTEE ON INDIGENT MEDICAL CARE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Indigent Medical Care has made a fairly intensive investigation of methods for medical services to the indigent. Being unable to find any comprehensive discussion of the picture, it became necessary to correspond with state, and state welfare officials over the entire United States, and to add the latest available statement of methods in several European countries.

After looking over the entire picture, we come to the regrettable conclusion that there is nothing like uniformity of methods, and the whole matter is a hodgepodge of illy-conceived plans, following ancient usages in local emergencies. There is no sound definition of indigency. The matter is tintured by local politics and by desire to avoid the term "charity." Rather generally, the tendency is to look upon provision for indigent care, unquestionably charity, as an alleged noble and humanitarian effort to give free services at public expense with minimum requirements of actual need or deserve.

It may be that the profession, in departing from our ancient custom of rendering free care to the deserving poor, as a recognition, in part, of the special status of doctors, and by requiring payments from public source, has partly commercialized the profession, has deteriorated its public relations, and in considerable degree brought on itself the demands for governmental plans. Under our older standards, there could not have arisen the solicitude for indigent and low income groups.

In Indiana, the legal responsibility of a township trustee for medical indigent care worked with

general satisfaction, for it was based on personal knowledge of need. It was abused by unscrupulous trustees and doctors, but in the main, is the most satisfactory and fair plan. Now, following a growing national pattern, indigent care is becoming a function of Welfare Boards, with greatly increased costs, growing dependency on official sources and lowering of personal standards.

In Indiana, the cost of indigent medical care for recipients of old-age assistance is now in excess of two and one-half million dollars annually, and is growing each month. To that is to be added the cost of medical care to dependent children, of one-quarter of a million dollars, and \$100,000 for the blind, and the costs of crippled children's care; and with required medical care programs for other indigents the cost to Indiana this year will exceed four million dollars. The new medical care plan is costly and its cost grows rapidly, with the common human tendency to abuse free services.

The committee does not yet have sufficient information to make recommendations. It has asked one of the universities to make a grant for a capable person to make a study as a thesis. This, with the promised statistics, ought to provide knowledge of the very large sums now disbursed, and might be of value in helping to settle the truth of claims of proponents of compulsory medicine that there is need for an all-inclusive medical program, because of unsatisfied needs of indigents and low income groups. The studies so far made indicate that no unsatisfied need presently exists and the claims made have a political, rather than an actual basis.

Arrangements have been made for special statistical information regularly from the Indiana State Welfare Board and other boards over the United States, and the Federal Security Agency.

The committee suggests that it be continued to carry on its studies.

W. U. KENNEDY, M.D., *Chairman*
MARS FERRELL, M.D.
A. P. HATTENDORF, M.D.,
G. H. SCHLEMMER, M.D.,
R. E. WILDMAN, M.D.,
ROBERT W. DONNELLY, M.D.,
FORREST E. KEELING, M.D.,
WILLIAM B. SIGMUND, M.D.,
F. N. DAUGHERTY, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

We have not as yet held a meeting this year, but we will do so in the near future. One of the problems was to work out a model set of sugges-

tions for nurses in industry which is well on the way to completion, and we hope will be ready to report to the state association at the fall meeting. We have seen that there have been multiple industrial meetings throughout the state during the past year. We think it is quite unnecessary to review the things that have been accomplished.

We have reviewed a report from the special committee of the Council on Medical Testimony, and it is our opinion that the censoring of the medical testimony should be done by the Council of the state medical association and not by a special committee. It is the feeling of the members of the Industrial Health Committee that far better results would be obtained and it would be much more impressive if the party or parties had to appear before the Council instead of a special committee. The Industrial Health Committee recommends to the Council that the report of the special Council committee be changed to read that the Council shall pass on questionable medical testimony, rather than a special committee.

If there are further recommendations or reports to be made, we shall make them as a supplementary report at the state meeting.

E. S. JONES, M.D., *Chairman*,
F. B. MOUNTAIN, M.D.,
JOHN HILBERT, M.D.,
LOWELL F. BEGGS, M.D.,
E. T. STAHL, M.D.,
H. D. CAYLOR, M. D.,
L. W. SPOLYAR, M.D.,
BRUCE STOCKING, M.D.,
R. B. SMALLWOOD, M. D.,
J. F. MAURER, M.D.,
H. R. WILBER, M.D.,
STANLEY M. CASEY, M.D.

COMMITTEE ON INSTRUCTIONAL COURSES

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Your Instructional Course Committee wishes to report that it is carrying out its assignment in preparation for the 1949 Session of the Indiana State Medical Association to the best of its ability.

It would now appear that the courses will be up to the usual standard.

GORDON W. BATMAN, M.D.,
RUSSELL A. SAGE, M.D.,
Co-chairmen,
J. LAWRENCE SIMS, M.D.,
HERBERT L. EGBERT, M.D.,
A. G. FUNKHOUSER, M.D.,
E. PAUL TISCHER, M.D.

COMMITTEE ON MATERNAL AND CHILD HEALTH

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Maternal and Child Health has been very active during the past year, holding three meetings, conducting other business by correspondence and telephone, and it has participated directly or indirectly in the promotion of the following programs and conferences: A plan for the institutional care of defective children under six years of age, the establishment of a criteria for the classification of all live births, participation in the State Conference for Planning on Children and Youth, preparation of the final report on the Child Care Survey of the American Academy of Pediatrics, a vision testing program for school children, an educational program in the field of maternal and child health, including newspaper publicity and the development of postgraduate education of physicians, and finally, and most important, the committee, in cooperation with the faculty of Indiana University School of Medicine, developed preliminary plans for the establishment of a Premature Care Training Center for nursery supervisors at Indiana University Medical Center.

The lack of facilities for the institutional care of mentally defective children under six years of age in Indiana has been of concern to the committee for some time. The committee can report that it exercised some influence along with the State Council for Mental Health and individual agencies in the procurement of facilities at Muscatatuck State Hospital. Seventeen beds are now provided, temporarily, in one of the quarters and an addition to the hospital of 100 beds for children under six years of age will be constructed in the near future.

There has been a need for uniformity in the reporting of live births. The committee prepared and distributed a Criteria for the Classification of All Live Births, and during the year made additions to these classifications which will be distributed again to practicing physicians and hospitals. Distribution of the criteria, as adopted, will be made by the Indiana State Board of Health.

Two members of the committee, Doctor Baxter and Doctor Jewett, represented the Indiana State Medical Association at the State Conference on Planning for Children and Youth, held in Indianapolis June 3. The purpose of the conference was to arrive at recommendations for the Governor for the purpose of improving local and state facilities for children and for closer integration of agency activities. The recommendations evolved were that the Governor appoint a State Council for Children to act as advisor to the Governor and to assist in the coordination and integration of all state and local services for children. This Council will also

represent Indiana at the White House Conference for Children to be convened by the President in Washington in 1950.

The committee has kept in close touch with the Child Care Survey of the American Academy of Pediatrics and it has arranged for the final report to be reviewed and approved by the committee and the Council of the State Medical Association before its publication and release. This report is now being put in its final form by the Academy Committee and the Indiana State Board of Health, and it will be published by the latter agency.

The Committee on Maternal and Child Health, in cooperation with the Committee on Conservation of Vision, approved a program proposed by the Indiana State Board of Health for the promotion of more uniform vision testing methods in public schools. With this approval, the Indiana State Board of Health will demonstrate the Massachusetts Vision Testing Kit and supervise the use of this vision testing method in public schools. The Massachusetts Kit has been approved by the Council on Physical Medicine of the American Medical Association.

The committee, in cooperation with the Indiana State Board of Health and Indiana University Medical School, resolved to promote better lay and professional education in the fields of maternal and child health. These plans will include newspaper publicity on the successes in reduction of mortality and morbidity in the state, and a postgraduate educational program for physicians, dentists and nursing personnel.

A premature infant care training center has been an objective of the Committee on Maternal and Child Health for a number of years. At a meeting of the committee with members of the faculty of Indiana University Medical School, preliminary plans were made for the establishment of such a center in the very near future. The faculty pledged its existing facilities for the development of a training program for nursery supervisors throughout the state and plans were discussed for the extension of the premature care services. The Indiana State Board of Health, with the approval of the association, will assist the medical center in extending the services and providing consultative services in the home where premature infants are returned. The objectives of the groups concerned are not to extend service programs greatly, but to provide adequate facilities and personnel for the training of nursery supervisors, who will return to the smaller institutions throughout the state equipped to give adequate care to premature infants born in their hospitals. This long range program, when fully developed, should do more to lower infant mortality than any other aspect of the child health program; and death from prematurity, which now ranks seventh in the ten leading causes of death, should be pushed down the ladder.

In submitting this annual report, the committee

pledges its continued enthusiastic interest in the field of maternal and child health in Indiana.

NEAL E. BAXTER, M.D., *Chairman*
G. W. GUSTAFSON, M.D.,
REX W. DIXON, M.D.,
H. W. EGGERS, M.D.,
JOHN S. HUONI, M.D.,
ROBERT O. ZINK, M.D.,
GEORGE W. WAGONER, M.D.,
EARL B. JEWELL, M.D.,
ROBERT E. JEWETT, M.D.

COMMITTEE ON MEDICAL AND NURSING SCHOOL SCHOLARSHIPS

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

This committee is happy to report that at the present time six students in the Indiana University School of Medicine and eleven young women in nurse training hospitals in the state are being assisted financially in procuring their education through scholarships awarded by the Indiana State Medical Association.

Two years ago the committee awarded a scholarship to a medical school junior. He has graduated and entered his internship. In another year he will be ready to fulfill the obligation imposed by the scholarship, i.e., to practice for a given period in an Indiana community needing a doctor. His scholarship is now available for assignment to another student.

An additional medical school scholarship paying \$200 annually has become available to the committee through the philanthropy of a physician's widow.

For the coming school year, 1949-1950, it appears at this time that the \$500 and \$200 medical school scholarships are all the committee will have to award. The eleven girls are expected to continue their nurse training, so no new nursing scholarships can be awarded unless additional money is received. Five of these eleven scholarships are possible through the generosity of two individuals, the association financing six of them.

The committee awarded a \$500 a year medical school scholarship to Kermit Q. Hibner of Indianapolis, and a \$200 a year scholarship to O. Fred Harless of Bloomington.

The committee is keeping a close check on the school work of the young men and women holding scholarships. Before checks are drawn for payments, the committee requires statements from the medical school and hospitals that satisfactory work is being done.

More worthy young men and women can be helped if the committee receives additional financial assistance. Physicians are urged to explain the

association's scholarship program to persons of means or to business organizations. Each contributor will receive full credit. The committee will handle all the administrative details, and the scholarship, if so desired, will bear the name of the donor.

C. J. CLARK, M.D., *Chairman*
HERMAN T. COMBS, M.D.,
HOWARD E. HILL, M.D.,
DON F. CAMERON, M.D.,
Ex-officio:
A. P. HAUSS, M.D.,
ALFRED ELLISON, M.D.,
J. WILLIAM WRIGHT, M.D.,
DON E. WOOD, M.D.

COMMITTEE ON MENTAL HEALTH

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

There were no matters referred to the Committee during this year. The Committee has been aware of the problems of mental health and those which are being dealt with under the Indiana Council for Mental Health. The state committee has stood ready to assist the Council in any way possible.

The Mental Health Committee has been interested and conversant with the progress made in the reorganization of the Indiana Society for Mental Hygiene. When the organization had reached an appropriate stage, the Mental Health Committee advised all county medical society secretaries of the aims and methods of the Mental Hygiene Society. One of these aims is the organization of local chapters throughout the state, and the Mental Health Committee urged the county societies to take an active interest in guiding the work of these local chapters.

A. M. DE ARMOND, M.D., *Chairman*,
L. P. HARSHMAN, M.D.,
E. VERNON HAHN, M.D.,
W. L. SHARP, M.D.,
G. E. METCALFE, M.D.,
H. C. BUHRMESTER, M.D.

COMMITTEE ON PREPAID MEDICAL AND HOSPITAL INSURANCE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Your committee met August 7, 1949, with the following members present: A. F. Weyerbacher, M.D., Bruce W. Stocking, M.D., and C. J. Clark, M.D. Others present were: Wemple Dodds, M.D.; Jesse E. Ferrell, M.D.; Albert Stump and R. S. Saylor.

This committee was created to establish a liaison directly between the Indiana State Medical Association and Mutual Medical Insurance, Inc. The reasons for maintaining such a committee might be itemized briefly as follows:

1. To draw representative physicians into active support of Blue Shield.
2. To expand the personal contacts of Blue Shield among members of the medical profession by securing invitations to their meetings.
3. To bring to the notice of Blue Shield suggestions or criticisms about Blue Shield; its method of operation and physician relations and benefits.

The first question that came up for discussion at the meeting was a fee for an assistant at the time of surgery. It was explained that the custom of paying the assistant varies in the different communities of the state. Sometimes the general practitioner handles the total bill with his patient and, through the general practitioner, pays the surgeon, the assistant and the anesthetist. Because of the variation of custom throughout the state, it was decided that Blue Shield should not be a party to changing any custom or arrangement that might exist. It was also the opinion of the committee that the general practitioner should be educated to the point that he is able to explain to his patient that the indemnity from Blue Shield is payment toward his surgeon's bill, and that his bill will be a separate bill for pre- and postoperative care.

Doctor Stocking then discussed the advisability of asking each county society to hold one meeting a year to talk about the Blue Shield program. He thought it would be better to have Blue Shield alone represented because there seems to be a misunderstanding among some doctors as to what Blue Cross is, and what Blue Shield is. This meeting might be combined with a meeting of the Auxiliary and include a discussion about compulsory health insurance by someone from the state office. It was suggested that "ISMA News Flashes" could be used to inform the county society secretaries to hold such a meeting.

Doctor Clark suggested that at some future state meeting some time should be devoted to the subject of the Blue Shield.

Considerable time was given over to the discussion of a comprehensive medical program, especially the including of house calls together with hospital and surgical service. A deductible contract was given consideration, when the member would pay the first \$25.00 and the plan would pay up to \$100.00, at \$5.00 per day of illness. It was the thought of the committee that this should be given further consideration before making any recommendations.

The committee recommends that this committee be enlarged to include one or two doctors from other sections of the state.

A. F. WEYERBACHER, M.D.,
Chairman,

BRUCE W. STOCKING, M.D.,
CYRUS J. CLARK, M.D.,
I. C. BARCLAY, M.D.

COMMITTEE ON RURAL HEALTH

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Rural Medical Care submits the following report of its activities for the past year.

February 3—Your committee chairman attended the meeting of the national and state committees on Rural Health of the American Medical Association, which met at the headquarters of the American Medical Association, Chicago, Illinois. The purpose of this conference was to determine the accomplishments to date of the various state committees on Rural Medical Care and for the purpose of interchanging information and planning.

February 4 and 5—The American Medical Association's Committee on Rural Health, under the leadership of Dr. F. S. Crockett of LaFayette, its chairman, called a meeting of all professional and lay groups interested in rural health problems at the Palmer House in Chicago for February 4 and 5, 1949. Your committee chairman was in attendance at this conference. The purpose of this conference was an intensive drive on the part of all interested groups to raise to new high levels the standards and availabilities of medical treatment in rural communities everywhere in America.

March 6—The first meeting of the Committee on Rural Medical Care was held at the Columbia Club in Indianapolis. Those present included the committee members; F. S. Crockett, M.D., LaFayette, chairman of the Committee on Rural Health of the American Medical Association; Mr. Ray E. Smith, Indianapolis, executive secretary and Mr. Larry Richardson, Indianapolis, field secretary and secretary to the Committee on Rural Medical Care.

Doctor Crockett opened the meeting with some background on the rural health movement. He conceived the problem of the Indiana Rural Medical Care Committee to be:

1. Transfer of the national objectives to the state level.

2. Getting full cooperation from nonmedical community groups. In 1946 Farm Bureau agents were asked to take the initiative in establishing community health councils, but after such groups had been formed, they failed to function because no program had been worked out for them to follow.

Doctor Crockett stated his own definition of a county health council as: "An organization representing all community groups, for the purpose of community improvement, aimed specifically toward better health for the individual and the general public."

The community health council idea has undergone a rebirth in Indiana due to the good services of Purdue University's Rural Extension Depart-

ment. The Indiana Board of Health has loaned Mr. Malcolm Mason, a native Hoosier and a University of Michigan graduate with a Master's Degree in Public Health, to Purdue for the express purpose of establishing health councils around the state, or revitalizing those still extant.

It was suggested at this meeting that one of the first problems of a newly created county health council should be to survey the health needs of its community. From that study should come clear recognition of one big problem which the health council could take immediate steps to remedy. It was the committee's feeling that Hoosier doctors should be well represented on these health councils and should be the authority and guide in all medical thinking done by the councils. It was also suggested that there is a need for awakening Indiana doctors to the necessity for working with lay groups interested in health improvement on the community level; that being in personal touch with lay groups would give the medical profession valuable clues as to the thinking of the public toward medicine, and would help us orient ourselves in the fight against socialized medicine.

The committee members wanted to know more about the 60 county health councils now functioning. Since the county health councils seem to be the logical vehicle for the medical profession in future attempts to improve rural health, the committee decided to invite Mr. Mason to the next meeting. Also to be invited were Dr. Leroy Burney and Dr. Daniel C. Barrett of the Public Health Service, these men to give the Rural Medical Care Committee a complete picture on existing organizations and activities in the field of rural medical care. The committee voted unanimously to submit a questionnaire concerning county health councils to the secretaries of their own and adjacent county societies, the results to be discussed at the next meeting.

March 20—The second meeting of the committee was held at the Columbia Club in Indianapolis. This meeting was attended by the committee members and by Dr. F. S. Crockett, ex-officio; Dr. A. P. Hauss, president, Indiana State Medical Association; Dr. Daniel C. Barrett, director, Local Health Administration, and Dr. Leroy Burney, director, State Board of Health; Mr. Malcolm Mason, Rural Extension Activities, Purdue University; and Harold Smith, Ph.D., Department of Sociology and Economics, Purdue University.

The county health council questionnaires were called in and examined. Returns were not complete but the indication was that they want medical profession leadership in the county health councils. This was in agreement with the findings of Mr. Mason from similar questionnaires sent out by him in his work at Purdue. He further added that there are twenty-two or more active health councils in Indiana today, and that where doctors had thrown full cooperation behind the councils they made excellent progress.

General discussion brought out that county health councils usually lacked strong leadership, and certainly one of the first steps in reorganizing such groups would be to appoint a recognized and responsible leader. Doctor Barrett suggested that Hoosier doctors need to be informed on what a county health council should do, then they, the doctors, should assume the leadership and general guidance.

During this meeting the ground work was laid for two state-wide health conferences to be held in June 1949. These conferences were to be attended by physicians, farmers and business people, to discuss the community health problems of the communities they represent and to organize the nucleus of local community health councils in each county throughout the state. It was decided to invite Dr. Carl S. Mundy, Toledo, Ohio, vice-chairman, American Medical Association Committee on Rural Health, to give the address at the first of these conferences; also to invite as moderator Dr. Claude S. Black of Warren, president-elect, Indiana State Medical Association. A subcommittee was appointed to meet at the home of Frank G. Sink, M.D., chairman, on March 21, to create an agenda for the two conferences. This committee was composed of Frank G. Sink, M.D., chairman, Margaret Bassett, M.D., Thorntown; Louis How, M.D., Lakeville; F. S. Crockett, M.D., Lafayette; Professor Harold F. Smith, Sociology Department, Purdue University; Mr. Malcolm Mason, Rural Extension Division, Purdue University.

March 21 and May 26—Meetings were held at the home of Frank G. Sink, M.D., Remington, chairman, with the subcommittee in attendance. Final arrangements were made and the programs planned for the two conferences to be held in June. The first of these conferences was held on June 16, 1949, in the Recreation Building at Culver Military Academy. The morning session included a panel discussion on "Organizing For Rural Health," with Claude S. Black, M.D., Warren, president-elect, Indiana State Medical Association as moderator. Panel members were:

Lester Hewitt, Ph.D., Muncie—"The Community Approach to Better Health."

Margaret Bassett, M.D., Thorntown—"How the Health Committee Aids the Rural General Practitioner."

Forrest Hummel, Logansport, Superintendent Cass County Schools—"Why Organize for the Health Problems Our Schools Face?"

Joseph H. Clevenger, M.D., Muncie—"How the Medical Profession Can Help the Health Committee."

The noon luncheon address was delivered by Carl S. Mundy, M.D., Toledo, Ohio, vice-chairman, American Medical Association Committee on Rural Health. The afternoon session included programs of active health councils as follows:

Mildred Schlosser, Terre Haute—"What Are The Community Health Resources?" "How Do We Discover Them?" "How We Can Use Them More Effectively."

Albert Wagner, Lakeville—"Whose Responsibility Is Rural Health and Who Should Take the Lead?"

Mrs. Sam Davis, Rockville—"How Important Are Health Surveys and How We Can Use Them."

Summary—James A. Waggener, Indianapolis, field secretary, Indiana State Medical Association. "Facing the Future."—Frank G. Sink, M.D., chairman.

The attendance at this session was as follows:

Physicians	20
Visiting physicians (Calif. 1—Ohio 1)	2
Auxiliary members	11
State Board of Health	4
County Health Councils	3
Lay attendance	22
—	—
Total	62

The second state-wide conference was held in the Union Building, Indiana University at Bloomington, Indiana, on June 23, 1949. The program was as follows:

Conference Purpose—Frank G. Sink, M.D., Remington.

Panel Discussion:—"Organizing For Rural Health." Claude S. Black, M.D., Moderator.

Panel Members:—Harold Smith, Ph.D., Lafayette, "The Community Approach to Better Health."

Margaret Bassett, M.D., Thorntown, "How the Health Committee Aids the Rural General Practitioner."

Wilbur Young, Osgood, Superintendent, Dearborn County Schools, "Why Organize For the Health Problems Our Schools Face?"

William S. Schoolfield, M.D., Orleans, "How the Medical Profession Can Help the Health Committee."

Discussion period.

Adjourn to Marine Room—Union Building for lunch.

Address—Dr. Herman B Wells, Bloomington, president, Indiana University.

Programs of Active Health Councils:

Mildred Schlosser, Terre Haute—"What Are The Community Health Resources?" "How Do We Discover Them?" "How We Can Use Them More Effectively."

Mrs. Homer L. Curry, Monroe County—"Whose Responsibility is Rural Health and Who Should Take The Lead?"

Mrs. Alice Gordon, Rockville—"How Important Are Health Surveys and How We Can Use Them."

Mrs. Jasper Reson, Clark County—"The Accomplishments of An Active Health Council."

Discussion period.

Summary—James A. Waggener, Indianapolis, field secretary, Indiana State Medical Association.

Facing the Future—Frank G. Sink, M.D., Chairman.

The attendance for this session was as follows:

Physicians	17
Auxiliary members	4
State Board of Health	5
County Health Councils	3
Lay attendance	12
—	—
Total	41

Combined attendance 103

The committee plans for a large state-wide conference in the early part of 1950.

FRANK G. SINK, M.D., *Chairman*,
MARGARET BASSETT, M.D.,
DAN L. URSCHER, M.D.,
L. W. VORE, M.D.,

H. N. SMITH, M.D.,
GEORGE S. ROW, M.D.,
WILLIAM SCHOOLFIELD, M.D.,
JOHN L. GWINN, M.D.,
LOUIS E. HOW, M.D.

COMMITTEE ON SCHOOL HEALTH
AND PHYSICAL EDUCATION

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The first meeting of the Committee on School Health and Physical Education was held April 27, 1949. Besides the members of the committee, guests present were Deane E. Walker, state superintendent of public instruction; Thurman B. Rice, M.D., professor of public health, Indiana University School of Medicine; Robert Yoho, Director, Division of Health Education, State Board of Health, and Ray E. Smith, executive secretary, Indiana State Medical Association.

The chairman was authorized to write a letter to the secretaries of the county medical societies, calling attention to the questionnaire received from the Bureau of Health Education of the A.M.A. on the school health program, and urging that they fill it out.

The question of using the radio health records available from the Bureau of Health Education, A.M.A., broadcast into the schools, was discussed and was referred to Dr. Schuman and Mr. Walker.

The committee voted to hold school health conferences similar to one which was so successful last year. These will probably be held in conjunction with three or four colleges in the different parts of the state, to which physicians, teachers, nurses, dentists and lay people will be invited. The office of the superintendent of public instruction and the State Board of Health are to be co-sponsors of these conferences with the committee.

A second meeting of the committee was held at the Columbia Club July 6. It was decided that the committee would cooperate with Mr. Yoho, Mr. Walker and representatives from about five colleges in different parts of the state in setting up the panel discussions this fall. Physicians located near these colleges will be urged to attend.

Arrangements are being made to have an exhibit on School Health and Physical Education at the annual meeting of the Indiana State Medical Association this fall.

B. N. LINGEMAN, M.D., *Chairman*
JOHN P. GENTILE, M.D.,
G. O. LARSON, M.D.,
J. H. CLEVINGER, M.D.,
GEORGE WILLISON, M.D.,
FRANCIS P. JONES, M.D.,
EDITH B. SCHUMAN, M.D.,
WILLIAM D. C. DAY, M.D.,
GEORGE V. CRING, M.D.

COMMITTEE ON STATE FAIR

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

As this report must of necessity be written before the opening of the 1949 State Fair, it will contain only the plans of the committee for participation in the annual exhibition. The supplemental report to be presented to the delegates on September 26, 1949, (after the fair is over) will be complete.

The committee met June 19, 1949, in the state association office to make arrangements for the exhibit. It was decided to employ three medical school students to take blood pressure readings of persons who visit the booth because of the popularity of this service in former years; to invite members of the Woman's Auxiliary to the Indianapolis Medical Society to serve as hostesses during the nine-day period of the fair; to procure three exhibits from the American Medical Association; to use a cartoon blow-up against socialized medicine as a part of the display, and to distribute literature against government control of medicine.

The State Board of Health allotted the committee its usual space in the southeast corner of the west health building. The committee wishes to gratefully acknowledge and thank the State Board of Health for giving the state association this space.

MALCOLM O. SCAMAHORN, M.D., *Chairman*,
WILLIAM D. PROVINCE, M.D.,
L. H. ELLIS, M.D.,
D. B. SILBERT, M.D.,
JAMES W. ASHER, M.D.,
RICHARD C. PRYOR, M.D.,
JOHN O. BUTLER, M.D.,
SAM W. CAMPBELL, M.D.,
WILLIAM W. WEAVER, M.D.

COMMITTEE ON TRAFFIC SAFETY

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

Your committee, after reviewing the program and plans of the State Traffic Safety Commission and State Traffic Safety Council, wishes to approve and endorse them in general, and to emphasize some phases included in the following recommendations:

1. The State Traffic Safety Commission and Council survey present speed laws in other states with a view to establishing a "prima facie" speed law in Indiana, which will provide a uniform basis for decisions in courts throughout the state.

2. Comparative study of the Indiana Traffic Code and revising it to bring it into conformity with the National Uniform Traffic Code.

3. Recommend that the State Drivers License Examiners be selected from capable and qualified applicants on a nonpartisan and merit system basis, and that they be certified as examiners only upon graduation from a recognized Drivers Training School.

4. We commend the present system of drivers records established by the Indiana Bureau of Motor Vehicles and recommend a continuous and critical review of such records in order to reveal the intentional and deliberate violators who are the cause of the greatest percentage of fatal accidents. We further recommend that in accordance with existing statutes, repeating offenders be cited before the chief hearing judge to show cause why their drivers license should not be suspended or revoked, according to the merits of the case.

5. Reconsideration of M.D. license plates to provide for and facilitate the emergency needs of physicians.

6. Revision of the present law compelling doctors, under heavy penalty, to report all epileptics, as such, which violates the rights of privileged communication. Replacement of such law by one providing for the reporting of ANY "physical condition which renders the patient unfit for driving"; the exact diagnosis to be given only on demand and with permission of the patient.

7. Extension of the services of Traffic Safety Engineer surveys to smaller communities, and enforcement of laws regulating traffic light installations only after survey shows need.

8. Provide the Indiana State Police System with adequate personnel to administer and enforce the traffic laws and program.

9. Detailed study and advance planning for a modern state highway system coordinated for the extension of existing super-highways and embracing fuller use of such safety engineering as proper banking, wide curves, cloverleaf turns, etc.

10. As a supplement to this committee, each County Medical Society appoint a Traffic Safety Committee of 3 physicians to assist at the county level in decisions as to physical defects which might disqualify drivers, such committee to work with local officers and Safety Councils.

This committee wishes to assure the Indiana Bureau of Motor Vehicles, the State Traffic Safety Commission and Council, and all groups concerned, of our continued assistance and cooperation in any possible way to implement and extend this program for traffic safety.

C. V. ROZELLE, M.D., *Chairman*
G. T. BOWERS, M.D.,
WILLIAM H. LANE, M.D.,
J. T. CARNEY, M.D.

COMMITTEE ON TUBERCULOSIS

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

This committee has not as yet held a formal meeting for the year. Such a meeting is planned during the 1949 convention of the state medical association at a luncheon to be held in the Murat Temple on Thursday, September 29, 1949.

The committee will meet jointly with the members of the county tuberculosis committees and members of the Indiana Chapter of the American College of Chest Physicians, and any other physicians who may be interested.

J. V. PACE, M.D., *Chairman*,
JAMES H. STYGALL, M.D.,
L. C. MARSHALL, M.D.,
T. R. OWENS, M.D.,
PHILIP H. BECKER, M.D.,
J. S. MCBRIDE, M.D.,
L. A. MALONE, M.D.,
E. W. CUSTER, M.D.

COMMITTEE ON VENEREAL DISEASE

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

The Committee on Venereal Disease has had no problems referred to it during the year 1949. Neither has there been anything called to the attention of the chairman of a nature to call a meeting of the committee.

It is the feeling of your chairman that each committee should have at least one meeting a year, but when there are no problems, I feel that it is better to use the finances and the energy of the committee members along lines that will give better results than simply holding a meeting without any other justification than to be able to say that the committee has met.

MINOR MILLER, M. D., *Chairman*
MYRON H. NOURSE, M.D.,
T. R. HAYES, M.D.,
W. C. MCCORMICK, M.D.,
ERNEST RUPEL, M.D.

COMMITTEE ON VETERANS AFFAIRS AND REHABILITATION

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

This committee has had two meetings. The first, in January, was largely devoted to efforts to give Reserve Medical Department Officers opportunity to maintain their active reserve status. The following letter was sent to the Surgeon General:

"On behalf of the Indiana State Medical Association representing some four thousand doctors in Indiana, we herewith approve and recommend the proposed training program being submitted for your approval by the Surgeon of the 2001st Logistical Division. It is quite important that Reserve Medical Department Officers be given every opportunity to maintain their active reserve status in such manner as that outlined in the above program.

"Any regularly scheduled medical meeting or recognized hospital staff should be included in this program."

In March our main topic of business was an effort to get volunteers from the recent graduates in medicine to enlist in the various branches of the service. A letter was sent to the medical societies with the names of those who had been deferred to enable them to continue their medical education. Our response from the doctors was not sufficient. Only eleven of one hundred seventy had volunteered up to April. After the chairman's report to the Council in April, that body passed the following resolution:

"To the American Medical Association:

"WHEREAS: Doctors have not volunteered in sufficient numbers to meet the armed services' requirements for medical men, and

"WHEREAS: Many doctors have been educated at total or partial government expense, and

"WHEREAS: Many doctors were deferred from service in order to complete their educational requirements, and

"WHEREAS: Unfavorable publicity toward the medical profession generally would be occasioned by a draft sought from other sources,

"Therefore Be It Resolved that the American Medical Association be requested to reconsider its previous stand, and take the leadership in guiding draft legislation for physicians."

A copy was sent to each recent graduate. This only stimulated seven more to volunteer. We were told that we needed forty physicians to meet the requirements of the services, and on last report we are twenty-two short of that figure.

There have been a few complaints by the veterans and also by participating physicians but these have been taken up on the individual case.

WILLIAM H. GARNER, M.D., *Chairman*,
CHARLES F. THOMPSON, M.D.,
W. W. WASHBURN, M.D.,
GLEN W. LEE, M.D.,
WILLIS PUGH, M.D.,
DUDLEY A. PFAFF, M.D.,
JAMES MCEWEN, M.D.,
J. M. KIRTLEY, M.D.

THE JOURNAL

*House of Delegates,
Indiana State Medical Association.*

Gentlemen:

In reporting to you on the progress of the publication of THE JOURNAL during my first year as editor, I would like to stress the teamwork which has made possible the continuation of the high standards set by my predecessors.

Dr. E. M. Shanklin, Editor Emeritus, has been prevented by reasons of health from taking an

active part in JOURNAL affairs, but has served as adviser and consultant. Plans have been made for his participation as an editorialist at a later date. It is the desire of THE JOURNAL staff to free him from the spade work as much as possible, and to make use of his long years of experience to whatever extent his health and desires will permit.

Careful attention has been given to the financial problems of THE JOURNAL by Ray E. Smith, the Managing Editor. The business report is contained in the Report of the Executive Committee. We are happy to note various economies and some amelioration in the price of printing. Despite a small decrease in advertising revenue, THE JOURNAL account has been maintained to date in a solvent condition.

The work of the Associate Editor, Dr. A. W. Cavins, has been especially valuable in the editorial department. Doctor Cavins has reviewed county medical society bulletins and other state journals, and has contributed editorials and editorial notes, and his own page, "Medical Panorama," based on the news published by other medical organizations. He has made several constructive suggestions in regard to the content of THE JOURNAL, which suggestions are now in the process of accomplishment.

The Editorial Board has been assigned the task of reviewing scientific articles submitted for publication. We have had a large number of contributions, all of which have been reviewed

independently by at least three members of the board. Their standards have been high. I believe that the material selected for publication has been of the best quality. The one rule of thumb which we have followed is that an article to be acceptable must be of interest and value to a significant proportion of the association's members, and particularly to the general practitioners.

Acknowledgment is due our Editorial Secretary, Mrs. Isabella Rowilson, and to Miss Lee Stanley, for their conscientious and painstaking work and genuine interest in the welfare of THE JOURNAL.

Because of the increased interest on the part of the medical profession in socio-economic affairs, the nonscientific portion of THE JOURNAL has been enlarged this year for the publication of as much information as possible on the subject of socialized medicine. Because of the high cost of printing this has necessarily reduced the scientific volume slightly.

THE JOURNAL has also, during the year of 1949, been planned to accommodate material for the celebration of the Centennial Anniversary of our State Association. The inclusion in the pages of THE JOURNAL of the text of "One Hundred Years of Indiana Medicine" will make possible the binding of this volume of medical history for future generations.

It has been an honor to serve as your Editor during the Centennial Year.

FRANK B. RAMSEY, M.D., *Editor*.

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HOUSE OF DELEGATES INDIANA STATE MEDICAL ASSOCIATION

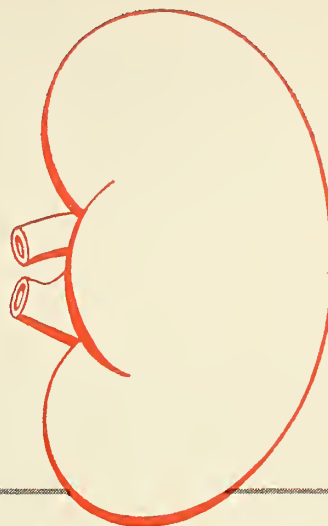
Indianapolis, Indiana
September 26, 27, 28 and 29, 1949

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Albert M. DeArmond, Indianapolis		SULLIVAN	
J. William Wright, Indianapolis		C. F. Briggs, Sullivan	C. E. Whipps, Carlisle
Harry R. Kerr, Indianapolis		SWITZERLAND	
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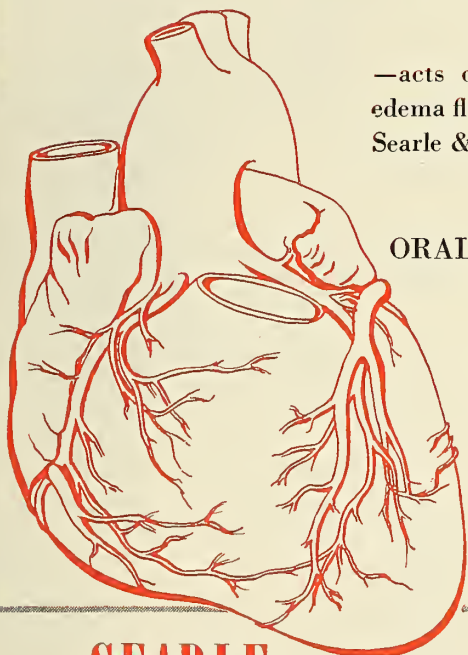
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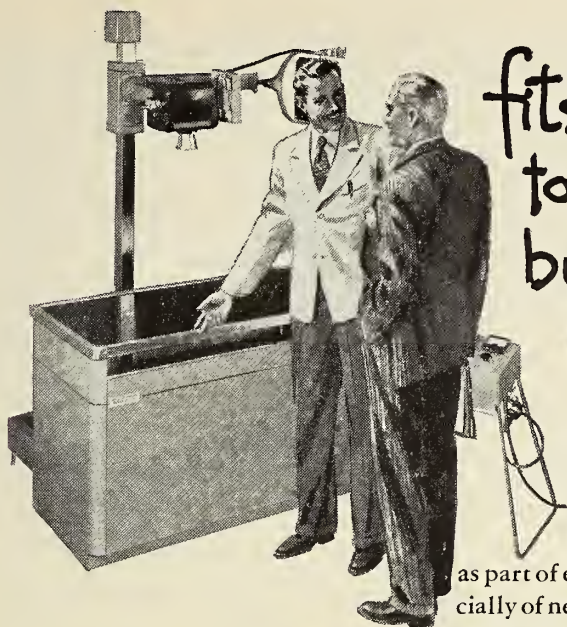
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1909	60th	Terre Haute	421	1929	80th	Evansville	814
1910	61st	Fort Wayne	450	1930	81st	Fort Wayne	1,115
1911	62nd	Indianapolis	748	1931	82nd	Indianapolis	1,033
1912	63rd	Indianapolis	590	1932	83rd	Michigan City	904
1913	64th	West Baden	312	1933	84th	French Lick	637
1914	65th	Lafayette	527	1934	85th	Indianapolis	1,814
1915	66th	Indianapolis	646	1935	86th	Gary	1,011
1916	67th	Fort Wayne	381	1936	87th	South Bend	1,150
1917	68th	Evansville	270	1937	88th	French Lick	1,154
1918	69th	Indianapolis	388	1938	89th	Indianapolis	1,751
1919	70th	Indianapolis	---	1939	90th	Fort Wayne	1,332
1920	71st	South Bend	421	1940	91st	French Lick	1,064
1921	72nd	Indianapolis	550	1941	92nd	Indianapolis	1,890
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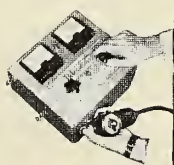


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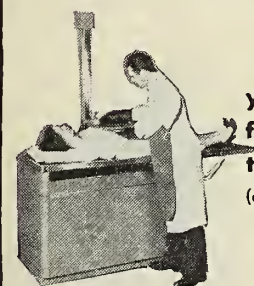
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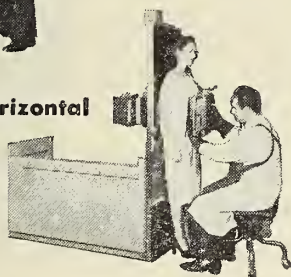
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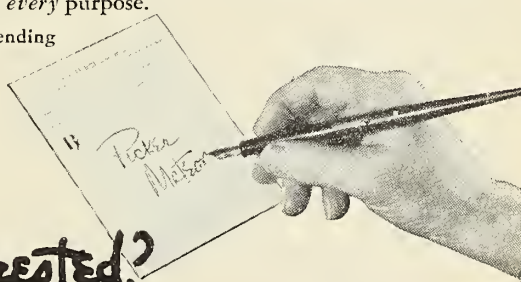
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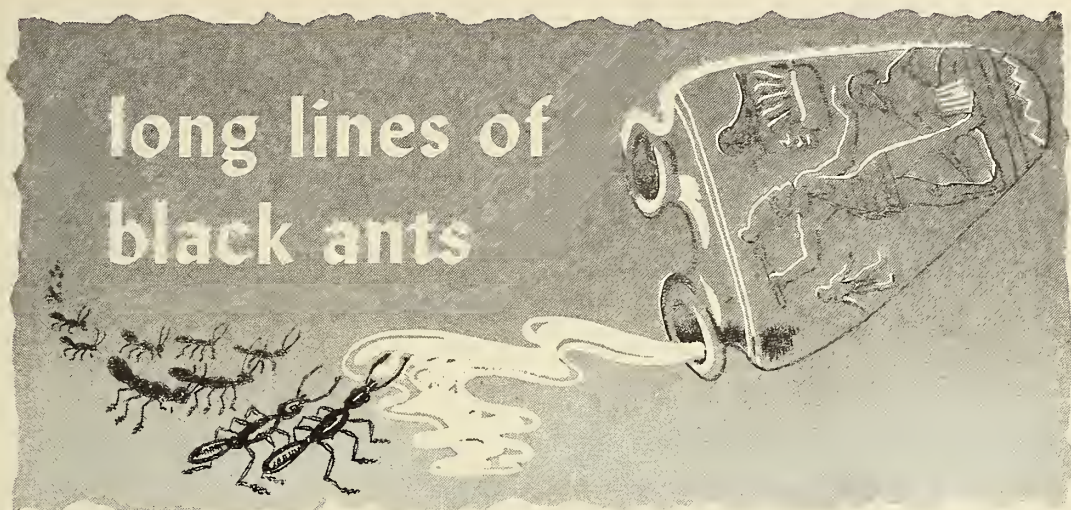


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St., Indianapolis, Ind. -----	109-110	PARKE, DAVIS & COMPANY, Detroit 32,	
DAIRY COUNCILS OF INDIANA, 115 E. Market		Mich. -----	69
St., Indianapolis, Ind. -----	90	THE PELTON & CRANE COMPANY, 632-652	
VICTOR DEITCH, Life Insurance and Annui-		Harper Ave., Detroit, Mich.	100
ties, 129 E. Market St., Indianapolis, Ind.	108	PET MILK SALES CORPORATION, 1401 Arcade	
DICK X-RAY COMPANY, INC., 443 N. Pennsyl-		Bldg., St. Louis, Mo.	62
vania St., Indianapolis, Ind., and 3976 Olive		PHILIP MORRIS & COMPANY LTD., INC., 119	
St., St. Louis, Mo.	106	Fifth Ave., New York, N. Y.	91
DIELMAN SURGICAL SUPPLY CO., 3843 Win-		PICKER X-RAY CORPORATION, 300 Fourth	
throp Ave., Indianapolis, Ind.	84	Ave., New York, N. Y.	53-54
THE DOHO CHEMICAL CORPORATION, 100		PITMAN-MOORE COMPANY, 1220 Madison	
Varick St., New York, N. Y.	40	Ave., Indianapolis, Ind.	25
EATON LABORATORIES, INC., Norwich, N. Y.	44	RICKRICH SURGICAL SUPPLY COMPANY, 801	
CARL LEON EDDY, 2439 Park Ave., Indianap-		W. Indiana St., Evansville, Ind.	41
olis, Ind. -----	10	A. H. ROBINS COMPANY, Richmond, Va.	76
ENCYCLOPAEDIA BRITANNICA, Inc., 20 N.		RYSTAN CO., INC., 7 N. MacQuesten Parkway,	
Wacker Drive, Chicago, Ill., and 966 N. Meri-		Mount Vernon, N.Y.	82
dian St., Indianapolis, Ind.	75	SANDOZ PHARMACEUTICALS, 68 Charlton St.,	
H. G. FISCHER & CO., 9451-9491 W. Belmont		New York, N. Y.	37
Ave., Franklin Park, Ill.	23	W. B. SAUNDERS COMPANY, West Washing-	
C. B. FLEET COMPANY, INC., 921 Commerce		ton Square, Philadelphia, Pa.	68
St., Lynchburg, Virginia -----	52	SCHENLEY LABORATORIES, INC., 350 Fifth	
FLINT, EATON & COMPANY, Decatur, Ill.	78	Ave., New York, N. Y.	5
FREEMAN X-RAY COMPANY, 4647 N. Cicero		SCHERING CORPORATION, 2 Broad St.,	
Ave., Chicago, Ill. -----	9	Bloomfield, N. J. -----	61
GENERAL ELECTRIC X-RAY CORPORATION,		G. D. SEARLE & CO., P. O. Box 5110, Chicago,	
4855 W. McGeech Ave., Milwaukee, Wis.	46	Ill. -----	1
GERBER PRODUCTS COMPANY, Fremont,		SEVEN-UP BOTTLING COMPANY, Indianap-	
Mich. -----	3	olis, Ind.	12
J. E. HANGER, INC., 1407 N. Illinois St., Indian-		SHARP & DOHME, INC., P. O. Box 7259, Phila-	
apolis, Ind. -----	49	delphia, Pa.	63
HANOVIA CHEMICAL & MFG. CO., Newark,		SHELLMAR PRODUCTS CORPORATION, Mount	
N. J. -----	38	Vernon, O. -----	72



Long lines of black ants attracted to madhumeha, "honey urine," led the ancient Hindu wise men to observe and recognize diabetic urine, which they described as "astringent, sweet, white and sharp." Avid insects became an acknowledged means of diagnosis. Almost equally primitive methods of urine-sugar detection remained in effect for a score or more of centuries, until modern copper reduction tests were perfected, refined and simplified.



Simplest of all today is the reliable *Ames* tablet method, performed in a matter of seconds. Urine-sugar levels are determined by direct, easily-learned steps. The use of *Clinitest* (Brand) reagent tablets has eliminated the inconvenience of external heating. Interpretation of routine urine-sugar testing follows readily from color scale comparison.

CLINITEST, trade mark reg. U.S. and Canada

*centuries to perfect
seconds to perform*



Clinitest[®]
for urine-sugar analysis

AMES COMPANY, INC. • ELKHART, INDIANA

Patronize Your Advertisers

	Booth Number
THE SMITH-DORSEY COMPANY, Lincoln, Neb.	59
SPENCER, INC., 135 Derby Ave., New Haven, Conn.	73
E. R. SQUIBB & SONS, 745 Fifth Ave., New York, N. Y.	47
STETHETRON SALES COMPANY, Wenonah, N. J.	19
STEWART'S INC., 44 E. Washington St., Indianapolis, Ind.	32
THE STUDEBAKER CORPORATION, South Bend, Ind.	111-112-113
TAYSON MANUFACTURING COMPANY, 310 E. Ohio St., Indianapolis, Ind.	81
U. S. VITAMIN CORPORATION, 250 E. 43rd St., New York, N. Y.	50
VAN PELT & BROWN, INC., Richmond, Va.	2
VARICK PHARMACAL COMPANY, INC., 75 Varick St., New York, N. Y.	87
WHITE LABORATORIES, INC., 113 N. 13th St., Newark, N. J.	30
WINTHROP-STEARNES INC., 170 Varick St., New York, N. Y.	85
WYETH INCORPORATED, 1600 Arch St., Philadelphia, Pa.	88
F. E. YOUNG & COMPANY, 422 East 75th St., Chicago, Ill.	39

ABBOTT LABORATORIES—BOOTH 11

Abbott Laboratories will exhibit an action model of the Aerohaler, a simplified device for administering finely powdered penicillin into the respiratory tract. It will show how the powder is shaken by impact from a sifter cartridge into a stream of air set up by the patient's inhalation.

AKRON SURGICAL HOUSE, INC. BOOTHS 55 AND 56

The Akron Surgical House, Inc., will have a display in Booths No. 55 and 56.

THE ALKALOL COMPANY—BOOTH 102

ALKALOL—The balance alkaline, saline solution for the treatment of mucous membranes and irritated tissues. Bland—Nontoxic—Effective. A favorite since 1896.

IRRIGOL—A powder which, in solution, makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

A. S. ALOE COMPANY—BOOTH 31

You are most welcome at booth No. 31 where the A. S. Aloe Company is displaying a large selection of new instruments and equipment for the modern doctor's office.

Featured is the Aloe line of physiotherapy equipment designed especially for the doctors' use and combining the utmost in functional utility with modest price.

AMERICAN HOSPITAL SUPPLY CORP.—BOOTH 89

Baxter Intravenous Solutions and Transfuso Vacs with disposable accessories; Blood grouping serums; Tomac Oral Protein Supplement—a remarkably palatable, A.M.A. accepted, non-hydrolyzed powdered Protein; the Tomac Oxygen Nebulizer; the new A.M.A. approved Monaghan Portable Respirator, new hope for polio patients; and a selected group of Tomac specialties.

AMES COMPANY, INC.—BOOTH 43

The Ames Selftester will be featured. This is an inexpensive urine-sugar detection kit containing two Clinitest tablets. The Selftester is designed for public use and is approved by the American Diabetes

Association as an aid to help detect the "million unknown diabetics" and to bring them under a physician's care.

THE ARMOUR LABORATORIES—BOOTH 24

The Armour Laboratories cordially invites members of the Indiana State Medical Association to visit the Armour Exhibit in Booth No. 24.

Information may be secured on many new items recently made available by The Armour Laboratories in the field of endocrinology.

ART METALS COMPANY, INC.—BOOTH 22

THE BAKER LABORATORIES, INC.—BOOTH 48

Baker's Modified Milk (Liquid and Powder) is made with Grade A cows' milk, fortified, adjusted and processed to obtain more efficient nutritive action and to insure better tolerance. Baker's has an adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron coupled with simplicity of preparation and low cost.

THE BORDEN COMPANY—BOOTH 6

A new, improved, better-than-ever BIOLAC is presented in Booth #6—better nutritionally and better physically. Unchanged are the dilutions, analysis, caloric values, vitamin fortification, and ease of feeding. This New Improved Biolac, a liquid modified milk for infant feeding, brings to you the latest findings of nutritional science . . . at no increase in cost.

Likewise exhibited will be our long-established products for infant feeding: DRYCO, MULL-SOY, MERRELL SOULF SPECIAL MILKS, general purpose KLIM, and BETA LACTOSE.

BROOKS APPLIANCE COMPANY—BOOTH 67

W. C. Ayer will have charge of the Brooks Appliance Company exhibit and will describe in detail the technique of applying the combination pressure bandages, Primer plus Dalzoflex, which are used in treating Osteo-Arthritis of the Knee Joints, Phlebitis and Varicose Leg Ulcers.

Proctological Instruments, Syringes, Needles and Elastic Hosiery will also be displayed.

BIRROUGHS WELLCOME & CO. (U.S.A.) INC. BOOTH 42

Among significant products featured will be 'WELLCOME' brand GLOBIN INSULIN with Zinc 'B. W. & Co.' the intermediate acting insulin; 'DEX-IN' brand High Dextrin Carbohydrate, in which the nonfermentable proportion predominates; DIGOXIN, the pure, stable, crystalline glycoside which offers predictable digitalization; and 'Tabloid' brand DIPHENAN, the new product for PINWORMS.

CAMEL CIGARETTES—BOOTHS 26 and 27

CAMEL Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking CAMEL Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking CAMELS."

CAMERON SURGICAL SPECIALTY COMPANY— BOOTH 70

See the new Suction Coagulation Handle and numerous accessories for all phases of Electro-Surgery, Electro-Cauterization, Electro-Coagulation, Desiccation and Fulguration; Cameron Surgical Units; Electro-Diagnostic Lamp and Instrument Outfits; the new stainless steel Boros Flexible Esophagoscope and other Peroral Equipment; Coagulair and Dualite Sigmoidoscopes; Tele-Vaginalite; Mirrolite and other Headlites; Binocular Loupes; Illuminated Specula, Endoscopes, Retractors and other instruments for all types of diagnosis, treatment and surgery.



QUESTION:

When is it good practice to suggest "Change to Philip Morris Cigarettes"?

ANSWER:

When patients under treatment for throat conditions persist in smoking, many eminent nose and throat specialists suggest "Change to Philip Morris"* ...the only cigarette proved** less irritating.

- *In fact, for all smokers, it is good practice to suggest "Change to Philip Morris."*

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc.

119 Fifth Avenue, New York

DO YOU SMOKE A PIPE? . . . We suggest an unusually fine new blend — COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

*Completely documented evidence on file.

**Reprints of published papers on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

CARNATION COMPANY—BOOTH 35

You are invited to visit booth 35 where you will see an attractive display on Carnation Evaporated Milk—"the milk every doctor knows." Some valuable information on the use of this milk for infant feeding, child feeding, and general diet will be presented, and the method by which Carnation is generously fortified with pure crystalline Vitamin D—400 U.S.P. units per reconstituted quart—will be explained. Interesting literature will also be available for distribution.

**THE CENTRAL PHARMACAL COMPANY—
BOOTH 51**

The Central Pharmacal Company display at the centennial convention of the Indiana State Medical Association will feature new, improved triple-sulfa products because they represent greater safety and effectiveness in the treatment of a large list of infections. These products have been accepted by the A.M.A. Council on Pharmacy and Chemistry.

The Synophylate, or Theophylline-Sodium Glycinate products, will be displayed since they represent superior forms of Theophylline based on better tolerance and increased effectiveness. Synophylate, or Theophylline-Sodium Glycinate, has also received the seal of approval of the A.M.A. Council.

Our Neocylate products will be prominently featured on the basis they represent the first definite improvement in salicylate therapy for over twenty years. Physicians will be interested in examining these products, since they will help solve many problems encountered in the treatment of rheumatic fever and other rheumatoid conditions.

A friendly welcome awaits all physicians who honor us by visiting the Central booth.

CHICAGO PHARMACAL COMPANY—BOOTH 107

The Chicago Pharmacal Company welcomes the physicians of Indiana to the exhibit. On display will be numerous packages and potencies of our U.S.P. alpha-ESTRADIOL in two convenient forms, sesame oil and micro-suspension. In addition to these we proudly present our DIGITOXIN tablets manufactured in our own laboratory from the crude drug, and our CALCIUM LEVULINATE ampuls which we believe to be a distinct improvement in calcium therapy. Chimedix representatives covering Indiana will be present at the meeting.

**CIBA PHARMACEUTICAL PRODUCTS, INC.—
BOOTH 29**

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, (Booth #29) invite you to visit their exhibit for latest information on CARMETHOSE, a non-systemic mucin-like colloid with a high acid combining quality. Also featured will be PRISCOLINE (formerly known as PRISCOL), a valuable adjunct to the treatment of peripheral vascular disease.

Representatives in attendance will gladly answer any questions about these and other Ciba products.

THE COCA-COLA COMPANY—BOOTH 80

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company, Indianapolis, and The Coca-Cola Company.

CURTIS & FRENCH, INC.—BOOTHS 109 and 110

Curtis & French will show all the latest instruments and equipment at their booth. Mack McCain, Ed Clark, G. L. Riley, Bill Kroegher, Jim Traub and Jack Curtis will be in attendance.

DAIRY COUNCILS OF INDIANA—BOOTH 90

You are cordially invited to visit the Dairy Council booth and examine our health education materials.

The exhibit is sponsored by the Dairy Councils of Evansville, Fort Wayne, Indianapolis, and South Bend. These units are affiliated with the National Dairy Council of Chicago, which is the health education organization of the dairy industry.

Dairy Council services and materials are free of charge in the localities which have affiliated units.

**VICTOR DEITCH, LIFE INSURANCE AND
ANNUITIES—BOOTH 108**

Victor Deitch, for many years, has been solving personal insurance and financial problems of doctors. Doctors have financial problems that can be solved to their greatest advantage through the use of life insurance and annuities.

By concentrating on physicians, a greater degree of proficiency is brought to bear for the benefit of this clientele.

Although many similarities exist in the doctors' insurance and financial pictures, yet individual differences call for experience in arriving at both a suitable and an economical solution in each case.

Only with a life insurance company can LIFE INCOMES be guaranteed to the doctor or his widow, immediately after the first deposit is made. More and more doctors are taking advantage of the money management service available through ownership of life insurance and annuities.

Only with a disability insurance company can adequate income be had for accident or illness disability. When the doctor gets sick or injured, his income stops.

Discussion of your problems invited.

DICK X-RAY COMPANY, INC.—BOOTH 106

The Dick X-Ray Company will have on display: Westinghouse X-Ray Equipment—Liebel-Flarsheim Short Wave Machines—Cambridge "Simpli-trol" Portable Electro-cardiograph—Fluorescent Viewers—Physiotherapy Equipment.

DIELMAN SURGICAL SUPPLY CO.—BOOTH 84

We invite you to stop at our booth, where we are featuring the LATEST EXAMINING TABLE. The Standard American has the added features that you have been looking for.

Mr. Dielman & Mr. Ashley will be waiting to show you many OTHER ITEMS of interest.

—REMEMBER—

"FOR A GOOD DEAL—DIELMAN"

DOHO CHEMICAL CORP.—BOOTH 40**EATON LABORATORIES, INC.—BOOTH 44**

Eaton Laboratories will exhibit several specialties.

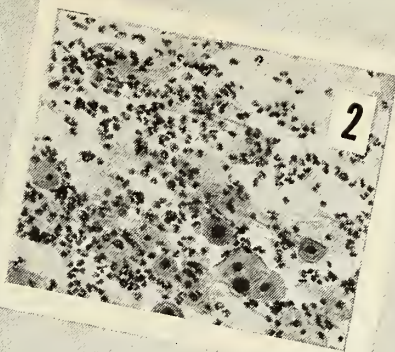
Furacin Soluble Dressing and Furacin Solution are topical antibacterial preparations which possess a wide antibacterial spectrum without injuring tissue.

Lorophyn Suppositories and Lorophyn Jelly are products for conception control of proven clinical effectiveness.

Aspogen is an amino acid-aluminum hydroxide compound used in the treatment of peptic ulcer. Its action is prompt and prolonged.

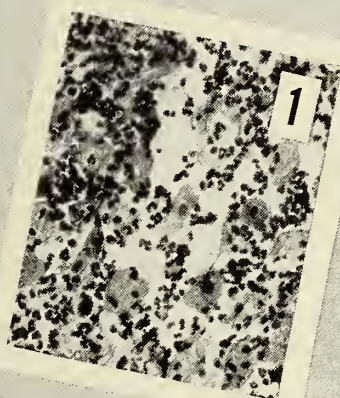
Untreated menopause. Epithelial cells are relatively small, large nuclei predominate; bacteria, leukocytes, free-floating nuclei and other debris cloud the smear picture.

1



2

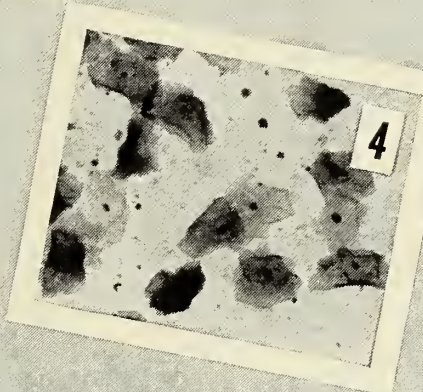
2 & 3 Smears showing progressive improvement during estrogen treatment. The picture is beginning to clear. The cells are enlarging and becoming more discrete.



1



3



4

4 Smear showing effects of full estrogen replacement. The smear is clean and free of leukocytes indicating restoration of a normal vaginal epithelium.



CONESTRON®

ESTROGENIC
SUBSTANCES
WATER-SOLUBLE

CONJUGATED
ESTROGENS
(EQUINE)

For action with little or no side action in control of menopause and certain other ovarian disorders.

CONESTRON, a complex of estrone, estradiol, equilin, equilenin and hippulin in the physiological conjugate obtained from the pregnant mare, supplies estrogens from natural sources, in the original, orally active form.

Conestron therapy produces a sense of well-being and is almost completely devoid of side reactions. Given in small, frequent, oral doses, Conestron permits a more uniform rate of absorption and maintains an effective level of blood estrogens.

Tablets of 0.625 and 1.25 mg., expressed as estrone sulfate. Bottles of 100 and 1000.



WYETH INCORPORATED, PHILADELPHIA 3, PA.

Patronize Your Advertisers

CARL LEON EDDY—BOOTH 10

Added to his physical therapy equipment line is the Dakon whirlpool bath, made in all sizes, from stationary or portable office units to the largest hospital size. An unusually sturdy and efficiently designed product.

The Rose line of genuine (the only quartz and tungsten seal) Cold Quartz ultra violet lamps, as well as the Rose short wave and Master Wave Generator galvanic and sinusoidal unit, is, of course, continued.

E. J. Rose was the first to manufacture, exclusively, electrical physical therapy equipment. The continuance of the business over forty-eight years is proof of the quality of the products.

The Gastro-Photot (stomach camera), completely redesigned and greatly improved since the war, together with, in most cases, a forty-eight-hour film development and diagnosis service, makes this device an outstandingly simple and valuable unit, not only for hospitals and clinics, but also for the general practitioner. Information regarding any of these items gladly furnished, and without any obligation whatsoever.

ENCYCLOPAEDIA BRITANNICA—BOOTH 75
160 MILES OF WORDS

The more than 38,000,000 words contained in the 1949 printing of Encyclopaedia Britannica is equivalent to more than 160 miles of words!

The 24 volumes, with its 27,200 pages and 17,588 illustrations, contain: 67 entirely new articles, 9 entirely new pictures and a revision over previous printings of over 2,000,000 words. Over 200,000 words were revised in the index volume alone.

Many of the articles relate to Atomic Energy; however, there are new articles on such things as: Sexual Behavior, Artificial Parthenogenesis, Coenogenesis, Electron Microscopy, and many others. The 17,588 illustrations constitute an extensive gallery of carefully chosen color plates, superb half-tones and technically correct line drawings. In many cases a Britannica illustration is the only authentic visual representation of a subject available anywhere. The new index volume contains over a half million references and cross references, and is the key to the entire work, making it possible to find the most illusive subject with ease.

Walter Yust, editor of Encyclopaedia Britannica, makes the statement that "The present Encyclopaedia Britannica is, in every respect from beginning to end, the most thorough, complete reference set available in the world today."

H. G. FISCHER & CO.—BOOTH 23

At Booth 23 inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let them point out many features of advantage in these representative units and other models not on display, and also explain their extremely liberal terms of sale. Your visit welcome—no obligation.

C. B. FLEET CO., INC.—BOOTH 52

C. B. Fleet Co., Inc., cordially invites you to stop by Booth No. 52 for a short visit with Mr. A. M. Kirkpatrick and Mr. John F. Alley, the representatives who see you in your office about once a year. Perhaps there is something about Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two U.S.P. Sodium Phosphates, you would like to discuss with them.

FLINT, EATON & COMPANY—BOOTH 78

The introduction of Choline therapy in early and late cirrhosis of the liver is one of the most interesting of recent medical developments. An easy and palatable way of administering Choline to your patients will be featured at Flint, Eaton & Company's booth. An up-to-the-minute edition of a very com-

prehensive digest on the present status of Choline therapy will be available. Interesting and unusual color photographs of liver pathology will also be featured.

FREEMAN X-RAY CO.—BOOTH 9**GENERAL ELECTRIC X-RAY CORPORATION**
BOOTH 46

The General Electric X-ray Corporation, Milwaukee, Wisconsin, with district offices at 306 Chamber of Commerce Building, Indianapolis 4, Indiana, will display the following items in Booth No. 46 at the Indiana State Medical Meeting:

General Electric Cardioscribe,

A new G. E. direct writing electrocardiograph.

A New Short Wave Diathermy.

A New Mobile X-ray Unit.

X-ray Supplies and Accessories.

GERBER'S BABY FOODS—BOOTH 3

GERBER'S presents the ONLY COMPLETE LINE of baby foods . . . Gerber's Cereal Trio, Strained and Junior fruits, vegetables, soups and desserts, PLUS Strained and Junior meats prepared from ARMOUR quality beef, veal and liver.

These meats for babies are kept at ready-to-serve temperatures for your examination and comparison. Ask the Gerber professional representative about them.

J. E. HANGER, INC.—BOOTH 49

Another year has passed, and we, the J. E. Hanger Company, manufacturers of artificial appliances, find ourselves preparing for the annual get-together with our friends of the medical profession.

You are again invited to visit our exhibit in Booth 49 where there will be displayed a complete line of prostheses. Your attention is especially called to the new suction socket limb and its unlimited possibilities for numbers of limb wearers.

We wish to express our heartfelt appreciation for your past cooperation and hope to be of service to you in the future.

Attending booth—

J. G. Best, Vice President.

S. E. Hedges.

HANOVIA CHEMICAL & MANUFACTURING
COMPANY—BOOTH 38

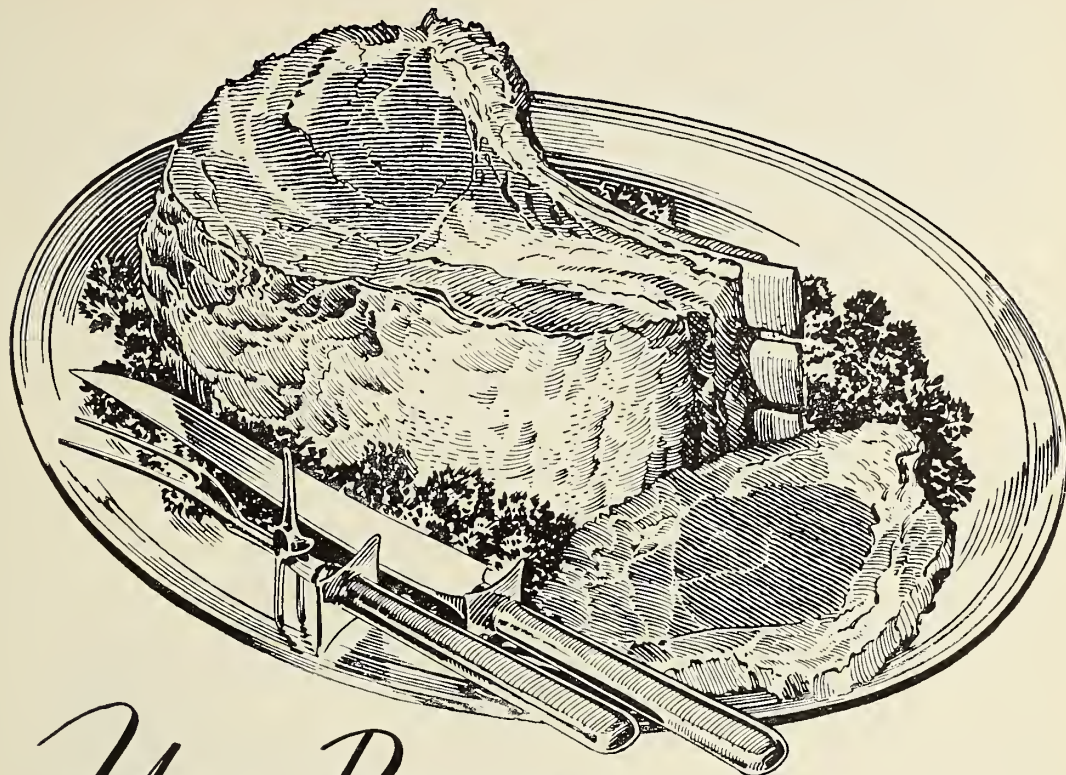
We welcome your visit to our exhibit to see demonstrated our new self-lighting ultraviolet quartz lamps for germicidal, body and official application. See the Wood's black light for diagnostic purposes, Sollux Radiant Heat Lamps and germicidal lamps for the destruction of air-borne bacteria. Competent and courteous representatives at your service.

H. J. HEINZ COMPANY—BOOTH 71

H. J. Heinz Company, Pittsburgh, will display Strained and Junior Foods, as well as a wide variety of nutrition material, at Booth 71. Doctors will find the products of interest not only for feeding infants and other small children, but also in gastro-intestinal cases, preoperative and post-operative disturbances, oral troubles, geriatrics, and a number of conditions where Strained and Junior Foods are required.

HOLLAND-RANTOS COMPANY, INC.—BOOTH 7

You will want to see the anatomically correct PELVI-FORM Clinical Teaching Model . . . an aid to visual demonstration of scientific contraceptive technique, for explaining gynecological conditions generally, and for establishing surgical approach. Improved package design of KOROMEX contraceptive specialties will interest you. Samples will be available upon request, not only of "Council-accepted" Koromex Jelly and Cream, but also of NYLMERATE JELLY, an effective trichomonacide that is inexpensive and convenient for patients to use at home.



Your Patients...

And the Meat They Eat

The established relationship between sound dietary planning and a state of maintained good health emphasizes the nutritional importance of meat, man's favorite protein food.

Not only does meat taste good, but of greater significance, it provides a host of nutritional benefits. Developments in the field of nutrition* have proved that complete protein—the kind that meat supplies in abundance—aids in building and maintaining immunity, hastens recovery after acute infectious diseases and following injury and burns, promotes health during pregnancy, aids in the growth and development of husky children, and is needed to maintain everyone in top physical condition.

No matter from what walk of life your patients come, and whether their pocketbooks demand economy or permit satisfaction of that urge for the fanciest cuts, meat gives them full value for their money.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

Patronize Your Advertisers

INDIANA VISUAL AIDS CO.—BOOTH 77

In the exhibit of INDIANA VISUAL AIDS CO., INC., Special Representative of the Bell & Howell Company, American Optical Company and Western Electric Company, you will find the ultimate in motion, still pictures, and sound distribution and reproducing equipment.

Bell & Howell Company has long been known as the one source of motion picture equipment embracing everything needed for the taking, editing, and projection of pictures; both motion in 8 and 16mm, as well as still pictures taken on 35mm film—with professional results from amateur use. A complete complement of this equipment can be seen in booth #77.

And for those who are interested in custom-built record reproducers and radio, both AM and FM, we are in a position to offer the finest, giving one that feeling of presence instead of a reproduction.

For the office there are intercommunicating systems designed to save countless steps.

Booth #77 is one booth at which you will want to spend time!

IRWIN, NEISLER & COMPANY—BOOTH 64

You are cordially invited to visit our exhibit. There will be displayed such clinically valuable products as Veratrite and Vertavis for the treatment of hypertension. A staff of trained professional service representatives will be in attendance to answer any of your questions and assist you in any way possible.

"JUNKET" BRAND FOODS DIVISION, CHR. HANSEN'S LABORATORY, INC.—BOOTH 66

The importance of rennet in infant and adult nutrition and the value of rennet desserts in both normal and restricted diets will be explained. Enlarged photos illustrate the action of the rennet enzyme in producing softer, finer, more readily-digestible milk curds. Authoritative literature is available describing dietary applications of rennet products. Complimentary packages of "Junket" Rennet Powder and "Junket" Rennet Tablets for the profession.

C. B. KENDALL CO.—BOOTH 57**LANTEEN MEDICAL LABORATORIES, INC. BOOTH 74**

LANTEEN MEDICAL LABORATORIES, INC., cordially invite you to visit their Booth No. 74. Representatives will discuss an improved diaphragm fitting technic used in conjunction with the well-known LANTEEN FLAT SPRING DIAPHRAGM. Other well-known LANTEEN products will also be featured in the exhibit.

LEDERLE LABORATORIES DIVISION—AMERICAN CYANAMID COMPANY—BOOTH 36

You are cordially invited to visit our exhibit in Space No. 36, where you will find representatives who are prepared to give you the latest information on Lederle products.

ELI LILLY AND COMPANY—BOOTH 58

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Space No. 58. Many new therapeutic developments will be featured and literature on these products will be available. Lilly medical service representatives are to be in attendance to aid visiting physicians in every way possible.

LINCOLN LABORATORIES, INC.—BOOTH 103

Lincoln Laboratories, Inc., a pioneer in the development of hormone aqueous suspensions, present their modern, all-glass ensemble for the display of a number of their leading, well-known parenteral medications. Aqueous Suspension of Estrogenic Substances will be featured. Trained representatives will be prepared to discuss hormone aqueous suspensions and other Lincoln specialties of interest to the physicians. Literature and professional samples are available.

J. B. LIPPINCOTT COMPANY—BOOTH 20

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken.

M & R DIETETIC LABORATORIES, INC.—BOOTH 65

Similac Division, M & R Dietetic Laboratories, Inc., Booth Number 65, will display Similac, a food for infants. Our representatives will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

MEAD JOHNSON & COMPANY—BOOTH 86

Amigen and Protolysate will be on display at the Mead Johnson Exhibit at your Indiana State Medical Association Convention. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than four hundred articles in the medical literature. Trained representatives will be at the Mead Exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pabulum, Pabena, Oleum Percomorphum and the other Mead Products used in Infant Nutrition. Protenum, a new high-protein product will be displayed; also Lonalac, for low-sodium diets.

THE MEDICAL PROTECTIVE COMPANY BOOTHS 33 AND 34

Please stop at Booths Nos. 33 and 34 and consult with our representatives there regarding our Specialized Service plan. As many of you know, The Medical Protective Company is observing its Golden Anniversary, and we are particularly anxious to give you the benefit of our fifty years' experience in concentrating our efforts solely on the legal liability problem of your profession.

THE WM. S. MERRELL COMPANY—BOOTH 28

"Its Name Is Nethaphyl" identifies Merrell's new drug for prompt symptomatic relief of bronchial asthma. In eight years of clinical experience, Nethaphyl has proven effective in 85-90 percent of the cases. Combining a more effective bronchodilator, a better tolerated myocardial stimulant and a mild sedative, it has demonstrated essential freedom from central stimulation or other side effects, effectiveness in epinephrine-fast patients, no increased tolerance or urinary retention, and non-interference with desensitization therapy. In one study, 87 percent of patients preferred Nethaphyl over other drugs. Merrell representatives will gladly discuss its action and give you samples for clinical trial.

THE C. V. MOSBY COMPANY—BOOTH 60

INTRODUCING...

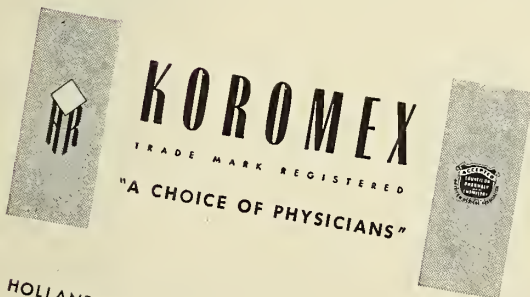


THE KOROMEX JELLY REFILLABLE UNIT

Physicians acclaim the new Koromex all inclusive contraceptive unit. This fine container is ivory-colored plastic, permanent, dust-proof, attractive for home use and ideal for traveling. It contains two regular size tubes of Koromex Jelly which rest in individual compartments... a Koromex Diaphragm stored in the ingeniously constructed cover compartment... and a Koromex Measured Dose Plunger Applicator that rests securely on its own rack.

Where pregnancy is contra-indicated, recommend the complete Koromex Jelly Refillable Unit to your discriminating women patients. For those of your patients who require a slightly less lubricating but equally effective spermicidal preparation, a similar companion package containing two tubes of Koromex Cream instead of Koromex Jelly is also available.

ACTIVE INGREDIENTS: BORIC ACID 2.0% OXYQUINOLIN BENZOATE 0.02% AND PHENYL MERCURIC ACETATE 0.02%, IN SUITABLE JELLY OR CREAM BASES.



HOLLAND-RANTOS COMPANY, INC., 145 HUDSON STREET, NEW YORK 13, N. Y.
MERLE L. YOUNGS • PRESIDENT

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MUTUAL MEDICAL INSURANCE, INC.—BOOTH 15

Mutual Medical Insurance, Inc. (Blue Shield-The Doctor's Plan) will have its exhibit in the southwest corner of the big convention hall; booth number is 15. An animated electrical display will tell the story of the growth of the Blue Shield and Blue Cross Plans and how they solve the problem of providing protection against the cost of illness for more than 34 million Americans. It will portray the fact that people who join the voluntary, nonprofit, physician and hospital sponsored Blue Shield and Blue Cross Plans sit on top of the world, with no worries about paying the cost of unexpected illness.

Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed commemorating the 100th anniversary of the Indiana State Medical Association.

Blue Shield will celebrate its third anniversary at the same time. During three years of operation, well over 300,000 people have joined the Plan and more than \$2,250,000 has been paid out to Indiana physicians for service rendered these members.

Dr. Walter U. Kennedy, New Castle, is president of The Blue Shield Plan; Dr. W. Harry Howard, Hammond, is vice-president; Dr. Walter L. Portteus, Franklin, is secretary; and Dr. A. F. Weyerbacher, Indianapolis, treasurer. These four, with Dr. C. J. Clark, Indianapolis, Dr. Wemple Dodds, Crawfordsville, and Dr. Jesse E. Ferrell, Fortville, serve as the executive committee for the Plan.

Administration of The Blue Shield Plan is under the direction of R. S. Saylor, Executive Vice-President, 400 Test Building, Indianapolis.

THE NATIONAL DRUG COMPANY—BOOTH 95

You are cordially invited to visit the booth of the National Drug Company. PROTINAL POWDER—delicious, intact, protein carbohydrate mixture, recently accepted by the Council on Foods and Nutrition of The American Medical Association—and RES-INAT—anion exchange resin antacid and pepsin inhibitor—will be the featured products. Samples and literature will be available at the booth. Representatives of The National Drug Company will be in attendance to answer inquiries concerning the above mentioned products as well as National's vast array of other pharmaceutical, biological and biochemical products.

WM. R. NIEDELSON CO.—BOOTH 13

The Jones Standard MOTOR-BASAL, and the new MULTI-BASAL, with its many new features designed to increase accuracy in the comparatively variable BMR test, will be shown.

Also, the new AMA Council-accepted CARDIO-TRON, the pioneer direct-recording cardiograph, with its unique permanent graph-writing mechanism, will be demonstrated. Stop in and try it or arrange to have it tried at your office. Mr. Murray Williams will be in charge.

**ORTHO PHARMACEUTICAL CORPORATION
BOOTH 45**

Ortho cordially invites you to visit their exhibit at Booth No. 45. Featured will be the new "Ortho Kit" with zipper bag which brings a new approach to the packaging of contraceptive items.

PARAVOX, INC.—BOOTH 96

The Paravox Neon Plastic Chassis Display, one of the most distinctive of its kind, has been used at numerous fairs and conventions throughout the nation and has received much favorable comment.

The display shows the steps, mounted in gold lettering on a black mirrored surface, in the assembly of Paravox Hearing Aids. Luminous plastic has been used to mold the chassis, and hidden neon tubes surround the display case of red and black fluted columns giving the unit back lighting.

PARKE, DAVIS & COMPANY—BOOTH 69

Members of the PARKE, DAVIS & COMPANY Medical Service Staff will be on hand at our Commercial Exhibit for consultation and general discussion of the Products classified in our Pharmaceutical, Antibiotic, and Biologic Lines. Important Specialties, such as Penicillin S-R, Benadryl, Vitamin Products, Hypnotics, Antibiotics, Etamon, Oxycel, Thrombin Topical, Influenza Virus Vaccine, and other Biologics, will be featured. You are cordially invited to visit our Booth with the assurance that your interest will indeed be very much appreciated.

THE PELTON & CRANE COMPANY—BOOTH 100**PET MILK COMPANY—BOOTH 62**

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

**PHILIP MORRIS & COMPANY, LTD., INC.
BOOTH 91**

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

**PICKER X-RAY CORPORATION
BOOTHS 53 AND 54**

PICKER X-RAY CORPORATION will exhibit the new practical x-ray unit at a popular price—THE METEOR. A patented tilting table-top feature provides for rapid and easy conversion from radiography to fluoroscopy in either horizontal or vertical positions.

PITMAN-MOORE COMPANY—BOOTH 25**RICKRICH SURGICAL SUPPLY COMPANY
BOOTH 41**

Messrs. George F. Carter, F. T. Farrell and I. J. Rickrich will welcome their friends in Booth 41.

New items in equipment and supplies will be shown.

A. H. ROBINS COMPANY—BOOTH 76

A. H. Robins Company, Inc., is exhibiting its entire line of ethical specialties, featuring the anti-arthritis PABALATE in both tablet and the new liquid form, the recently introduced digestant ENTOZYME, and Robins' new antitussive-expectorant, ROBITUS-SIN. Clinical samples and informational literature will be available.

RYSTAN COMPANY, INC.—BOOTH 82**SANDOZ PHARMACEUTICALS—BOOTH 37**

We invite all physicians to visit Booth No. 37, where Sandoz Pharmaceuticals are featuring Cafergone Tablets (E.C. 110), the first really effective oral migraine treatment.

When Histamine Cephalgia and tension headaches are impending or under way—Cafergone tablets are also indicated. Cafergone tablets either check the attack abruptly in the early stage, *actually preventing the onset of pain*, or they interrupt the progress of the attack, *markedly shortening it and reducing it in severity*. Cafergone is available in tablet form only.

Among other products displayed are: Dihydroergotamine (D.H.E. 45), Belladonal, Bellergal and Mesantoin.



IN HAY FEVER

HIGH Antihistaminic Potency HIGH Index of Safety

High antihistaminic potency, combined with a high index of safety and a relatively low incidence of side effects, recommend Neo-Antergan* for prompt, safe, symptomatic relief in hay fever and other allergic manifestations.

In a recent clinical study¹ in which several leading antihistaminic compounds were employed, Neo-Antergan was found to have little or no sedative effect in the majority of patients, and became *the favorite medication of ambulatory patients who were treated with more than one antihistaminic agent.*



Your local pharmacy
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in 25 mg. and 50 mg. tablets,
supplied in packages of 100 and 1,000.

*Neo-Antergan is the registered trade-mark of Merck & Co., Inc. for its brand of pyranisamine.

1. Brewster, J. M., U. S. Naval Med. Bull. 49: 1-11, January-February 1949.

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COUNCIL  ACCEPTED



MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

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W. B. SAUNDERS COMPANY—BOOTH 68

We invite all doctors attending the meeting of the Indiana State Medical Association to visit our exhibit, where we will display a complete line of our books, including Hyman's "Integrated Practice of Medicine," Bockus' "Gastro-enterology," Conn's "Current Therapy," Meleney's "Treatment of Surgical Infections," Snyder's "Obstetric Analgesia and Anesthesia," Lyons & Woodhall's "Atlas of Peripheral Nerve Injuries," Crile's "Practical Aspects of Thyroid Disease," DeGowin, Hardin & Alsever's "Blood Transfusion," Levine & Harvey's "Clinical Auscultation of the Heart," Fine's "Care of the Surgical Patient," Pepper's "Medical Terminology," Lichtenstein's "Neuropathology," Boies' "Otolaryngology," 1948 Mayo Clinic Volume, new editions of McLester's "Nutrition and Diet in Health and Disease," Weiss & English's "Psychosomatic Medicine," Stieglitz' "Geriatric Medicine," Cantarow & Trumper's "Clinical Biochemistry," Christopher's "Textbook of Surgery," Berens' "Diseases of the Eye," Orr's "Operations of General Surgery," and many others.

SCHENLEY LABORATORIES, INC.—BOOTH 5

The Schenley Laboratories' exhibit features Titalac, an extremely palatable antacid with a titration curve very similar to that of milk. Also on display will be Rutaminal, an exclusive Schenley specialty combining rutin, aminophylline, and phenobarbital; Orapens—buffered penicillin tablets of varying strengths; Monocillin, a procaine penicillin product producing 96-hour blood levels; and Aquacillin, procaine penicillin for aqueous injection. Samples of various products will be available.

Well-informed personnel will be in attendance.

SCHERING CORPORATION—BOOTH 61

Buccal Tablets of Oreton, Progynon, Proluton, and Cortate with the new base Polyhydrol, will be featured at the Schering exhibit. Developed in the Schering research laboratories, the new Polyhydrol base provides a means of completely utilizing hormones without the necessity of injection. **Chlor-Trimeton and Trimeton**, outstanding antihistaminics, and **Thalamyd**, Schering's brand of phthalylsulfacetamide, a new sulfonamide extremely effective in ulcerative colitis and enteric infections, will highlight the exhibit.

Schering's representatives will be present to welcome you and will be happy to answer inquiries concerning Schering's new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

G. D. SEARLE & Co.—BOOTH 1

You are cordially invited to visit the Searle booth, where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Dramamine for the prevention and active treatment of motion sickness; Alidase, for hypodermoclysis; Ruphyllin, for abnormal capillary fragility; Hydryllin, new and effective antihistaminic, as well as such time-proven products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatine and Pavatrine with Phenobarbital.

SEVEN-UP BOTTLING COMPANY—BOOTH 12**SHARP & DOHME—BOOTH 63**

Visitors attending the Indiana State Medical Association meeting are cordially invited to visit the Sharp & Dohme exhibit in Booth No. 63. Stable, portable "Lyovac" Normal Human Plasma irradiated to destroy not only bacteria but also the viral contaminants that might cause homologous serum hepatitis, merits your attention. Unusual specialties, including the popular sulfonamide and antibiotic drugs, also will be of major interest.

Courteous attendants will be pleased to serve you.

SHELLMAR PRODUCTS CORPORATION—BOOTH 72

The Shellmar exhibit will be of the Shellie Nurser and will be in the charge of Mr. W. J. Rigby, head of our Shellies Division, assisted by one or more trained nurse demonstrators.

The Shellie Nurser in our opinion is the greatest improvement in the technique of infant feeding that has been developed in the past twenty-five or fifty years. It consists of a collapsible, disposable container made of sterilized plastic film with an entirely new type of nipple having contours which duplicate those of the human breast. Because the container is flexible, it collapses as formula is withdrawn, thus practically eliminating the swallowing of air, which is a principal cause of colic in infants.

THE SMITH-DORSEY COMPANY—BOOTH 59

Aminophylline Suppositories, Mercurophylline Injectable U.S.P., and Aqueous Suspension of Estrogenic Substances will be on display at Dorsey's booth. Other outstanding Council-accepted products will be featured. A cordial invitation is extended to visit the Dorsey exhibit.

SPENCER, INCORPORATED—BOOTH 73

On display will be Spencer Supports for abdomen, back, and breasts—*individually designed* to meet the medical indications of each individual patient. Of special interest is Spencer's new COLOSTOMY support design—an unusually effective aid in training of the colostomy patient. Other special features include the Spencer Abdominal Spring Pad (patented), *removable* rigid steels for spinal supports, mastectomy breast support with breast form, a "hammock-type" support for antepartum patients. See also Spencer's Blood Pressure Sleeve—fits any size arm, provides *quick, accurate* readings.

E. R. SQUIBB & SONS—BOOTH 47

E. R. Squibb & Sons will feature new professional specialties. Also on display will be such widely accepted products as Crysticillin, Tolserol, Rubramin, Amnestrogen and the Penicillin Dispolator.

The representatives in attendance will be pleased to discuss these and other Squibb products with you. Please visit Booth 47.

STETHETRON SALES COMPANY—BOOTH 19

The Stethetron Sales Company, national distributors of the Maico Electronic Stethoscope, demonstrate Council-accepted electronic auscultation, a necessary addition to the modern diagnostic armamentarium. This pocket size unit provides any degree of body sound amplification, overcoming the tremendous office and street noise levels for the normal ear and compensating for any acquired hearing loss so often present at the distal ends of the hearing curve. Portable Teaching Units for twelve listeners are also exhibited.

STEWART'S INC.—BOOTH 32

Stewart's Inc., Indiana's oldest Book Store, appreciates the invitation to show you their books at the Centennial Convention. Among the many titles will be **ATOMIC MEDICINE** by C. F. Behrens, M.D. Why not place your order in advance to be assured a "first printing?" Many titles will be shown and among them we feel sure you will find books useful in your profession or for your personal enjoyment.

**THE STUDEBAKER CORPORATION—
BOOTHS 111-112-113**

FULL POTENTIALITIES OF THEOPHYLLINE THERAPY REALIZED...

SYNOPHYLATE

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BRAND OF

THEOPHYLLINE-SODIUM GLYCINATE

DOSAGE BARRIER REMOVED: Theophylline dosage can now be pushed to levels which provide the optimal benefits of the medication. SYNOPHYLATE* is well tolerated: irritative effect on the gastric mucosa is minimized. Its high degree of solubility permits prompt absorption with rapid clinical effect.

FLEXIBILITY OF DOSAGE: Three dosage forms of SYNOPHYLATE facilitate adaptation of the medication to the needs of the individual.

Tablets SYNOPHYLATE: 0.33 Gm. (5 grains), equivalent to 0.165 Gm. (2½ grains) Theophylline U.S.P.; bottles of 100, 500, and 1,000. Tablets of 0.165 Gm. (2½ grains) also available.

Syrup SYNOPHYLATE: Each teaspoonful (4 cc.) contains 0.33 Gm. (5 grains) SYNOPHYLATE, equivalent to 0.165 Gm. (2½ grains) Theophylline U.S.P.; bottles of 1 pt. and 1 gal.

Suppositories SYNOPHYLATE, Rectal: Each suppository contains 0.78 Gm. (12 grains) SYNOPHYLATE, equivalent to 0.39 Gm. (6 grains) Theophylline U.S.P.; cartons of 12 foil-wrapped suppositories.

*Trademark of The Central Pharmacal Co.

THE CENTRAL PHARMACAL COMPANY

Pharmaceutical Progress Since 1904

SEYMOUR...



...INDIANA

Patronize Your Advertisers

TAYSON MFG. COMPANY—BOOTH 81

The Tayson Mfg. Company, manufacturers of Orthopedic and Surgical Appliances, cordially invites you to visit their Booth Number 81 where it has on exhibition various types of braces and supports.

The exhibit is attended by G. P. Jackson and K. K. Taylor.

U. S. VITAMIN CORPORATION—BOOTH 50

Exhibit demonstrates the greatest vitamin technological advance of the present decade . . . "oil-in-water" multi-vitamin solutions...includes Vi-Syneral Injectable which makes available for the first time in pharmaceutical history, an *aqueous* parenteral multi-vitamin solution with the liposoluble vitamins A, D and E, together with ascorbic acid and B complex factors in a water solution, ready for immediate injections; also, the *original oral aqueous* multi-vitamin formula, Vi-Syneral Vitamin Drops . . . since 1943.

Professional samples and literature distributed on these two pharmaceutical "firsts," along with our full line of nutritional specialties, including Tri-Sulfanyl, Methischol, Vi-Syneral capsules, Poly-B, Vi-Litron, Hypervitamin, Lipo-Heplex and others.

VARICK PHARMACAL COMPANY, INC.—BOOTH 57

The makers of Digitaline Nativelle, the original digitalin, have prepared an interesting and informative exhibit on new and broader concepts of treating the failing heart. Emphasis is given to the role of Digitaline (Nativelle), the preparation of choice in congestive failure.

Literature and samples of Digitaline will be available, as well as copies of our recently published, "Low Sodium Diet," brochure. We cordially invite you to visit our exhibit.

Mr. A. W. Jones will be in charge.

WHITE LABORATORIES, INC.—BOOTH 30

At this booth will be an interesting display of this firm's products. Trained Medical Service Representatives in attendance will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of the recent products of White's research. You are cordially invited to visit this booth.

WINTHROP-STEARN'S INC.—BOOTH 85

Winthrop-Stearns Inc., New York, extends a cordial invitation to visit its booth No. 85, where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be: Meharal, sedative and anti-epileptic—produces tranquility without drowsiness; Isuprel, new, more efficient and convenient bronchodilator—tablets for sublingual use, solution for inhalation; Neocurtasal, sodium-free seasoning agent.

WYETH, INCORPORATED—BOOTH 88

Wyeth, Incorporated—Meonine, Vipeptolac, Amphojel, Neohetramine, as well as the new antidiarrhetic kaomagma with Pectin, vitamin and mineral enriched S.M.A., Purodigin and Free Testosterone are among the many outstanding ethical pharmaceutical specialties which will be featured at the Wyeth booth. Trained representatives will be on hand to answer questions and supply the latest literature on these preparations.

Obstetricians particularly will find Vipeptolac and Council-accepted Meonine valuable for the management of prenatal patients. Vipeptolac is a delicious hydrolysate compound fortified with vitamins and minerals for the prevention of overall nutritional deficiency. Meonine exerts a specific action in protecting the liver, and is indicated for the prevention and treatment of toxemias of pregnancy.

F. E. YOUNG & COMPANY—BOOTH 39

F. E. Young & Company, Booth No. 39, will exhibit Young's Dilators, Sulf-A-Test, Young's PSP Test Set and Young's Albumin Test.

Young's Dilators are used in the treatment and prevention of contracted anus, particularly following hemorrhoidectomy, as an aid in perineal dissection, and in the repair following delivery. Register for recent reprints.

Sulf-A-Test, Young's PSP Test Set, and Young's Albumin Test, will be demonstrated. These are accurate, rapid office tests, replacing the more time-consuming laboratory methods.

CENTENNIAL CONVENTION TO BE BROADCAST

Arrangements have been completed to carry the Tuesday, September 27, evening program on a state-wide radio hookup. This will consist of a half hour show featuring the Baltimore and Ohio Glee Club of Baltimore, Maryland.

The program will originate from the stage at the Murat Theater beginning at 8:30 o'clock (central standard time) and will be broadcast by the following stations at the time indicated.

WFBM Indianapolis (8:30-9:00)

WIND Gary (8:30-9:00)

WTHI Terre Haute (8:30-9:00)

WGBF Evansville (10:15-10:45)

WAVE Louisville, Ky. (9:00-9:30)

WOWO Fort Wayne (9:00-9:30)

WBAA Lafayette (8:30-9:00)

The program will also be carried on the following FM stations from 8:30 to 9:00 p.m.: WFMU Crawfordville; WMRI Marion; WCHB Connersville; WCTW New Castle; WSRK Shelbyville; WFML Washington and WRSW Warsaw.

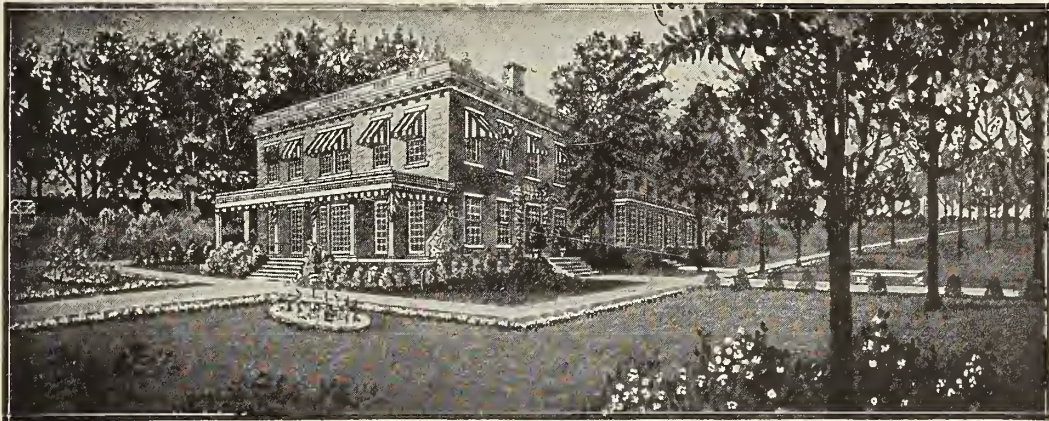
County societies could issue invitations to the public in their communities to hear this program by running announcements in their local newspapers.

ALCOHOLISM
SENILITY
DRUG ADDICTION

A Modern Ethical Sanitarium at Louisville

Established 1904

NERVOUS
AND
MENTAL DISEASES



BEAUTIFUL AND SPACIOUS GROUNDS AFFORD OUTDOOR RELAXATION

Our **ALCOHOLIC** treatment destroys the craving, restores the appetite and sleep, and rebuilds the physical and nervous condition of the patient. Liquors withdrawn gradually, no limit on the amount necessary to prevent or relieve delirium.

MENTAL patients have every comfort that their home affords.

The **DRUG** treatment is one of gradual reduction; it relieves the constipation, restores the appetite and sleep; withdrawal pains are absent. No Hyoscine or rapid withdrawal methods used unless patient desires same.

NERVOUS patients are accepted by us for observation and diagnosis as well as treatment.

Select cases of **SENILITY** accepted.

Physiotherapy—Clinical Laboratory—X-ray

Consulting Physicians

Rates and folder
on request.

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Medical Director

ROY KINZER
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Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

MEDICINE OF THE YEAR. First Issue, By Hugh J. Morgan, M.D., Professor of Medicine, Vanderbilt University; Frank Whitacre, M.D., Professor of Obstetrics and Gynecology, University of Tennessee; Henry G. Poncher, M.D., Professor of Pediatrics, University of Illinois; Warren H. Cole, M.D., Professor of Surgery, University of Illinois; 143 pages. Cloth. Price \$5.00. J. B. Lippincott Company, East Washington Square, Philadelphia, Pennsylvania.

YOUR CHILD MAKES SENSE. A Guidebook for Parents. By Edith Buxbaum, Ph.D. 204 pages. Cloth. Price \$3.25. International Universities Press, 227 West 13th Street, New York 11, New York.

MEDICAL ETYMOLOGY. The History and Derivation of Medical Terms for Students of Medicine, Dentistry, and Nursing. By O. H. Perry Pepper, M.D., Professor of Medicine, University of Pennsylvania. 263 pages. Cloth. Price \$5.50. W. B. Saunders Company, West Washington Square, Philadelphia, Pennsylvania.

THE COMPLETE PEDIATRICIAN. Practical, Diagnostic, Therapeutic and Preventive Pediatrics, By W. C. Davison, M.D., Professor of Pediatrics, Duke University School of Medicine. 256 pages. Cloth. Price \$5.00. Duke University Press, P. O. Box #3701, Durham, North Carolina.

TONICS AND SEDATIVES. By Morris Fishbein, M.D., Editor of "The Journal of the American Medical Association." 120 pages. Cloth. Price \$2.00. 51 original drawings. J. B. Lippincott Company, East Washington Square, Philadelphia.

SOIL, FOOD AND HEALTH. "You are what you eat." By Jonathan Forman, B.A., M.D., F.A., C.A. and O. E. Fink, M.A. 342 pages. Price \$4.50. Friends of the Land, Columbus, Ohio.

LIMBO TOWER. By William Lindsay Gresham. 275 pages. Cloth. Price \$3.00. Rinehart and Company, Inc., New York, New York.

THE PRACTICE OF REFRACTION. By Sir Stewart Duke-Elder, M.D. 317 pages, 216 illustrations. Cloth. Price \$6.25. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri.

ATLAS OF ROENTGENOGRAPHIC POSITION. By Vinita Merrill, while Educational Director Picker X-Ray Corporation. (In two volumes) 663 pages. Cloth. Price \$30.00. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri.

BOOKS REVIEWED

GERIATRIC MEDICINE—The Care of the Aging and the Aged. By Edward J. Stieglitz, M.D., Attending Internist, Suburban Hospital, Bethesda, Maryland; Doctor's Hospital, Washington, D. C. New, Second Edition, 773 pages, with 180 figures. Cloth. Price \$12.00. W. B. Saunders Company, Philadelphia and London, 1949.

This book is both textbook and reference work. Well edited and compiled, it comes from the pens of forty-seven contributors, all able and outstanding.

The phenomenon of aging has been of universal interest as far back as records go, yet very little really scientific and accurate understanding of it has

been accumulated. This book takes what knowledge we do have, adds what is available in modern technology, plus a dash of practical philosophy and comes up with a very satisfactory geriatric menu. Of course the book is departmentalized, by body systems and diseases, but the first seven chapters on the general subject of geriatrics are well done and give one a good picture of the "normal" physical and personality changes in senescence and old age. The chapter on medicolegal aspects of senility is well written, but seems too concise to be in keeping with the rest of the book, especially since physicians are none too strong on medicolegal knowledge in general.

In the remainder of this work (36 chapters) there is a wealth of material on the ills that aging flesh is heir to. Even one of great experience would do well to consult this volume before deciding that he knows all about geriatrics. He will find an adequate index.

PSYCHOSOMATIC MEDICINE. The Clinical Application of Psychopathology to General Medical Problems: By Edward Weiss, M.D., Professor of Clinical Medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M.D., Professor of Psychiatry, Temple University Medical School, Philadelphia. New, (2nd) Edition. 803 pages. Philadelphia and London: W. B. Saunders Company, 1949. Price \$9.50.

On the flyleaf of this book is a quotation from Plato: "For this is the great error of our day . . . that physicians separate the soul from the body." The text is in two main divisions: 1) General Aspects of Psychosomatic Medicine, and 2) Special Applications to General Medicine and the Specialties; with a total of 24 chapters, appendix, references and index.

The authors first stress the point that "the diagnosis of 'functional' illness must be established not simply by exclusion of organic disease, but on its own characteristics as well." These characteristics and analyses of their basis, or origin, are really what the book is all about.

In the chapter on Personality Development and Psychopathology there is material for a refresher course in psychiatry presented with greater clarity than is usual for this subject. Under "Psychosomatic Diagnosis" is a highly interesting and helpful section on history-taking, good for any Doctor of Medicine, no matter what his field, if he deals with patients.

It is of course impossible to give a real review of this kind of book in a short space and many chapters cannot be mentioned at all. Through the entire discussions of Part Two are woven many illustrative case histories, which also serve as models of history-taking. Another important feature, is emphasis at intervals of the difference between major and minor psychotherapy, degrees of severity of the different neuroses, and other data which should help the average physician to determine whether a specialist is needed. Regarding the general physician they state: "Even more important than study, however, are the physician's feelings for the patient as a human being and the realization that illness is an aspect of human behavior."

On the whole, this is a well written and stimulating book, apparently intended for non-psychiatrists who undoubtedly will not agree with everything in it, but who certainly may improve their psychiatric alertness by exposure to its ideas. A. W. C.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 42

OCTOBER, 1949

NUMBER 10

TOE PEDICLES IN RECONSTRUCTION OF THE FOREFOOT

JAMES A. McCLINTOCK, M.D.

MUNCIE

INJURY to the foot in the metatarsal area is relatively common. It is the part of the foot most exposed to injuries of a crushing type. In industrial accidents chemical and thermal burns frequently involve this region. In military experience and in civilian hunting accidents, a variety of missiles have caused damage to this portion of the forefoot. Such injuries may be slight, but often there is great damage, with loss of substance which may involve bones, tendons, vascular and nerve supply, and soft tissue covering of the foot. Of this more serious group some cases leave no choice but amputation. An even larger group of patients with severe injuries eventually can be given a useful foot, but only after multiple operations over a long period of time, with consequent great loss of productivity on the part of the patient. Therefore, before reconstruction is started, the factors influencing the outcome should be considered.

EVALUATION OF FOOT

Soft tissue infection must be eradicated before reconstruction is attempted. Any foot with causalgia, Sudeck's atrophy, or related syndromes, should be corrected by sympathetic blocks or lumbar sympathectomy before reconstruction is started.

The osseous tissues should be carefully evaluated. Chronic osteomyelitis, once such a problem, now seems to be a controllable situation, as attested by several recent papers.^{1, 2} A potentially stable foot should be a matter of some concern. Satisfactory walking depends to a great extent upon the shifting of the weight from the os calcis to the heads of the first and fifth metatarsals. The great toe

and, to a much lesser extent, the other toes, have an important function in giving a "push off" effect to the stride. There is little point in repairing the soft tissue of a foot if the skeletal structure cannot be made adequate. Some feet that are satisfactory from the standpoint of stability are lacking in another important respect—soft tissue durability. The soft tissue must be able to stand up under the wear and tear of average usage. Scars and split skin grafts seldom hold up when average stress is applied, so they are usually replaced with a pedicle flap. Impaired circulation and nerve damage, with loss of sensation, almost certainly will lead to a breakdown of soft tissue over friction points. In fact, even a well padded pedicle flap shifted to the foot must be protected through a rather long period of toughening and return of sensation before it will tolerate average trauma.

ADVANTAGE OF TOE PEDICLE OVER CONVENTIONAL FLAP

Amputation has sometimes been considered because of the long period of time required to transfer a pedicle flap to correct a soft tissue defect in the foot, and the even longer time required for the flap to develop durability. It has come to our attention that a relatively simple, one-stage surgical procedure, using the toes as a pedicle flap, may save time in some of these cases, and often gives a better functional result than that obtained with a more conventional procedure.

APPLICABILITY OF METHOD

This method of reconstruction is applicable in those cases with loss of soft tissue involving the

Figure 1



Figure II



One Year After Toe Pedicle Surgery

dorsum of the foot in the area overlying the metatarsals. Such a patient usually presents an unsatisfactory scar covering of the defect. Often the extensor tendons of the toes are lost and the toes are functionless or even a hindrance in walking. If in such a case the toes have relatively normal tissue the method may be useful. Good sensation as shown by pin prick and touch, and good capillary circulation as shown by blanching on pressure and return of color on release, are helpful in evaluating the toes. It should be emphasized that if the defect to be repaired extends over the tarsals then this method cannot be used. If any doubt exists as to the ability of the available toes to cover the defect this can be ascertained before surgery. Each toe being considered will cover a defect as long as the distance from the metatarsophalangeal joint to the tip of the toe and will cover a width almost equal to the circumference of the toe. It is well to remember in this regard that the defect may have been subjected to much scarring, in which case when the scar is excised the defect will be appreciably larger than in its contracted state. The area that a toe will cover is surprising. An average small toe will repair a defect up to 2 by 2 inches, and a middle toe will fill a defect 3 by 2½ inches. We have not as yet found it necessary to use the great or second toe in repairing any defects and would hesitate to use the great toe in this manner, preferring to save it for its "push-off" function in walking.

OPERATIVE TECHNIQUE

If after evaluation the foot meets the above requirements, then the patient is prepared for the operation. Twenty-four hours before surgery parenteral penicillin therapy is begun and the foot and leg are given a thorough orthopedic type of preparation.

In the operating room, after anesthesia is administered, the foot and leg are again prepared with green soap, saline, ether and merthiolate, and draping is carried out to expose the entire foot. No tourniquet is used. All scar is excised and all portions of the defect are cut back to a freely bleeding base. Pressure is applied temporarily to stop the ooze. Small bleeding vessels may usually be controlled with the pressure of a hemostat left in place for a few minutes.

The selected toes are now prepared for use as pedicle flaps. An incision is made down the dorsum of the toe from the metatarsophalangeal joint to the base of the nail. The incision is carried to bone and is extended around the nail out to the tip. Using a towel clip to grasp the distal phalanx, the soft tissue is cut free from the bony framework of the toe. Care is used in keeping the incision close to the bone to preserve blood and nerve supply. No effort is made to dissect out or remove tendons or fascial structures. They are allowed to remain as part of the soft tissue pad. The phalanges are removed by disarticulation at the metatarsophalangeal joint. There is some tendency for the toe to resume its cylindrical form. Two short, oblique incisions through the tip of the toe will allow it to assume a flat shape more readily. The less trimming done, the better the blood supply.

The toe pedicle thus created consists of an anatomical unit with relatively normal circulation, nerve supply and good subcutaneous padding. There is little tendency to shrinkage. The toes rotate through 180 degrees with no circulatory embarrassment. The pedicle can easily be fitted to the defect on the foot and any peripheral excess may be trimmed away. A few buried sutures may be desirable to tack the pedicle more firmly to its bed and the periphery is sewed skin-to-skin with multiple interrupted silk sutures.

A dressing is applied, using an ace bandage over gauze fluffs or mechanic's waste, for continuous light resilient pressure. A short leg cast is applied to immobilize the foot for seven to ten days. At the end of that time sutures are removed and early motion begun. Weight-bearing is usually prohibited for two weeks to be sure healing is secure. Penicillin is continued until the time of the first dressing.

Postoperatively the previous volar surface of the toe pedicle tends to keep its rounded contour, but over several months, as the cornified layers diminish and as the pressure of shoes and new stresses come into play, flattening takes place. The patient at first notices touch over the pedicle as if it were still in its location on the volar surface. Later sensation is interpreted in the dorsal position.

CASE PRESENTATION

A 26-year old, colored female received a severe burn of the dorsum of the right foot in June, 1946. She was first seen by us in December, 1947. At that time, despite 18 months of local therapy, there was a granulating area over the metatarsals and over the dorsum of the toes. The second, third, fourth and fifth toes were held in complete dorsiflexion by the contracting scar tissue. The patient had been unable to wear a shoe or to work during this entire time.

On December 20, 1947, after preparation as described above, all of the scarred tissue was excised.

The extensor tendons of the third, fourth and fifth toes were replaced by scar, but the tendons to the great and second toes were intact. After the scar was excised the second toe could be placed in a normal position; however there was a denuded area over the proximal phalanx. The third, fourth and fifth toes were prepared as described for pedicle flaps and were used to cover the defect over the metatarsals and over the proximal phalanx of the second toes. The patient went home January 4, 1948, and was followed through the outpatient clinic. Figures 1 and 2 show the results after a year of hard usage. The patient walks without a limp and works at a job which involves standing much of the time.

CONCLUSIONS

A method is presented whereby toes may be used in a one-stage procedure to fill soft tissue defects in the dorsum of the foot requiring pedicle type of reconstruction.

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MIDWEST REGIONAL MEETING AMERICAN COLLEGE OF PHYSICIANS

Claypool Hotel

INDIANAPOLIS

9:00 a.m.—5:00 p.m.

November 19, 1949

The Fellows of the American College of Physicians wish to invite all members of the Indiana State Medical Association to attend the Midwest Regional Meeting of the American College of Physicians, in Indianapolis, November 19, 1949.

An interesting program will be presented by physicians from Minnesota, Wisconsin, Iowa, Illinois, Michigan, Ohio and Indiana.

THE PRESENT-DAY CONCEPT OF ADRENAL CORTICAL PHYSIOLOGY WITH REFERENCE TO THE TREATMENT OF ADDISON'S DISEASE BY GLANDULAR TRANSPLANT

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INDIANAPOLIS

IN 1855 Thomas Addison¹ contributed the first comprehensive report of the clinical picture of the disease that today bears his name. Little has been added to his classical description of the eleven cases.

Until recent years the functions of the adrenal cortex were completely unknown and the production of epinephrine was thought to be the sole, or at least the most important, function of the entire gland. Swingle and Remington² contributed much original work relating to the adrenal cortex. Many data have been accumulated since their contributions, but many more important chapters will undoubtedly be added in the future concerning the normal and abnormal physiology of these glands. The accompanying chart (after Hamblen³) lists the recognized functions of the adrenal cortex.

Renal Function

- (a) Enhances tubular resorption of sodium and water and favors the excretion of potassium.
- (b) Increases renal blood flow, facilitating the excretion of nonprotein nitrogen, inorganic phosphorus and sulfate, urea and creatinine.

Carbohydrate Metabolism

- (a) Favors glycogen storage and glyconeogenesis from protein.
- (b) Affords some protection against carbohydrate utilization. Cortical insufficiency is characterized by depletion of glycogen depots and by increased insulin sensitivity.

Nitrogen and Muscle Metabolism

- (a) Favors nitrogen elimination by the kidneys and depletes body protein for glyconeogenesis.
- (b) Promotes muscle efficiency. The characteristic adynamia of cortical failure results from disturbances in electrolyte, water and carbohydrate metabolism.

Vascular System

- (a) Maintains efficient blood pressure levels by its influence on electrolyte and water metabolism and, perhaps, by inhibiting capillary dilatation.

Nervous System

- (a) Protects against pain, stress, and changes in temperature probably by virtue of its effect on electrolyte, water, and carbohydrate metabolism.

Sexual System

- (a) Considered by many workers to be the primary

gland in steroid synthesis, manufacturing not only its steroidal needs, but also being closely associated with the gonads in their hormonal metabolism. The facts that sexual alterations are produced by certain adrenal tumors, that estrogens, progesterone and androgens have been isolated from the cortex, and that varying amounts of gonadal steroids are excreted after gonadectomy, support this belief. The question as to whether this secretion of gonadal hormones is purposeful or whether these steroids are merely by-products of syntheses designed solely to supply cortical requirements remains to be clarified.

A considerable amount of work regarding the role of the cortical hormones in antibody activity has recently been reported.^{4, 5} The clinical manifestations of adrenal dysfunction together with animal experimentation has taught us a great deal about these functions. Hartman,⁶ Prunty,⁷ and Rogoff⁸ demonstrated that adrenal cortical extracts have life-preserving properties. Long⁹ and his group emphasized the role of adrenal hormones in carbohydrate and protein metabolism. In 1932 Loeb¹⁰ described the influence of the adrenal cortex upon electrolyte metabolism. Later Kendall^{11, 12} reported on the steroid compounds including Compound E. Mason,^{13, 14} and Talbott,¹⁵ and their co-workers have contributed much to the fractionation of these compounds.

4. Thatcher, J. W., Houghton, B. C., and Ziegler, C. H.: Effect of adrenalectomy and adrenal cortical hormone upon the formation of antibodies, *Endocrinology*, 1948, xliii, 440.
5. Browne, J. S. L., Herbert, P. H., and deVries, J. A.: The effect of adrenocorticotrophin on antibody levels in normal human subjects. Paper read Assoc. Internal Secretions meeting, June, 1948, Chicago.
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2. Swingle, W. W., and Remington, J. W.: The role of the adrenal cortex in physiological processes, *Physiol. Rev.*, 1944, xxiv, 89.
3. Hamblen, E. C.: *Endocrinology of woman*, 1947, Charles C. Thomas, Springfield, Ill., p. 22.

The chemistry of these hormones has been established by these and other workers. Sayers¹⁶ suggests the possible synthesis in the body from cholesterol since these compounds have a similar basic configuration. Chart I shows the chemistry and physiological actions of several of the more important steroid hormones.

One of these hormones is a substance similar to—and perhaps the same as—the synthetic hormone, desoxycorticosterone, described by Steiger and Reichstein.¹⁷ Harrop¹⁸ discussed the profound effect upon the renal tubules, selectively stimulating them to reabsorb sodium and chloride, and probably inhibiting their ability to reabsorb potassium. Other steroid compounds have now been isolated which precipitate marked breakdown of protein molecules to form carbohydrate, by gluconeogenesis.¹⁵ They also improve muscle efficiency. Albright¹⁹ and his group recently described a hormone, yet to be definitely proven, that has a protein anabolic effect. It acts in a similar manner to testosterone.

The metabolic end products of the hormones of the adrenal cortex are excreted in the urine. Many are found in the 17-ketosteroid fraction. These have been subdivided into the alpha and beta fractions.^{20, 21} The beta fraction is derived from the adrenal, whereas the alpha may arise from the adrenal or the testis. Allen,²² in discussing the Cober modification test for steroids, feels that the dehydroisoandrosterone, a beta fraction, is of extreme importance in the differentiation of adrenal cortical hyperplasia from adrenal tumor.

14. Mason, H. L., and Kepler, E. J.: Urinary steroids isolated after administration of dehydroisoandrosterone to human subjects, *J. Biol. Chem.*, 1947, clxvii, 73.

15. Talbot, N. B., Albright, F., Saltzman, A. H., Zygmuntowicz, A., and Wixom, R.: Excretion of 11-oxycorticosteroid-like substance by normal and abnormal subjects, *J. Clin. Endocrinology*, 1947, vii, 331.

16. Sayers, G., Sayers, M. A., Liang, T. Y., and Long, C. N. H.: Effect of pituitary adrenotrophic hormone on cholesterol and ascorbic acid content of the adrenal of the rat and the guinea pig, *Endocrinology*, 1946, xxxviii, 1.

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Chart I

STRUCTURE	COMMON NAME	SOURCE	PREDOMINATE ACTIVITY
	CORTICOSTERONE	ADRENAL	GLUCO-CORTICOID
	DEHYDROCORTICOSTERONE	ADRENAL	GLUCO-CORTICOID
	DEHYDRO-ISO-ANDROSTERONE	URINE	TESTOID
	DESOXYCORTICOSTERONE OR 11 DESOXYCORTICOSTERONE	ADRENAL	MINERAL O-CORTICOID
	17-HYDROXY-11-DEHYDROCORTICOSTERONE KENDALL'S CPD. "E"	ADRENAL	GLUCO-CORTICOID
	PROGESTERONE	OVARY	LUTEOID
	TESTOSTERONE	TESTIS	TESTOID

AFTER - SELYE'S, "TEXTBOOK OF ENDOCRINOLOGY".

Venning and Browne²³ recently advanced an interesting concept of the mechanism whereby these hormonal interrelationships produce clinical syndromes. An increase or decrease in the production of these hormones by the cortex reflects a hyper- or hypofunction of the adrenal, depending upon the relative amounts of various substances secreted. Thus an overabundance of the hormone affecting electrolyte metabolism may be responsible for the clinical hypertension, whereas a moderate increase of the "sugar"¹⁹ steroid may be responsible for the diabetic picture. An increase or decrease of the 17-ketosteroids may manifest itself clinically by precocity, or by lack of sexual development. Venning and Browne feel, therefore, that it is a quantitative and a qualitative variation that is responsible for the variety of metabolic and clinical disorders seen in Addison's disease, Cushing's disease, and the adrenal-genital syndrome.

Whether the adrenal cortex manufactures all of these hormones is not definitely known, but some basic chemical reactions in the organism require the presence of the adrenal cortical hormones, hence the many dysfunctions manifested in so many tissues in the absence of these hormones.

Patients with Addison's disease have a typical history of progressive weakness, weight loss, pigmentation of the skin and mucous membrane, disturbance of hair growth, hypotension, and loss of libido. Adrenal crisis is characterized by the occurrence of profound hypotension, peripheral vascular collapse, and coma. This state may be precipitated in a patient with Addison's disease by inadequate treatment or by the occurrence of a concomitant febrile disease.

Addison's disease is characterized pathologically by destruction or atrophy of the adrenal gland. Tuberculosis is responsible in approximately 50 percent of the cases. Atrophy of the gland, which is undoubtedly related to pituitary failure, is associated with a syndrome of pan-hypopituitarism in which there is a lack of the trophic stimulating factor.

The diagnosis of Addison's disease is ordinarily not difficult. It involves great responsibility for the physician as these patients are seriously ill. Since the disease is a progressive one, the cost of care is of great importance. The diagnosis is based on the following:

(a) History and clinical manifestations as mentioned previously.

(b) X-ray evidence of adrenal disease—primarily calcification.

(c) Results of specific adrenal function tests. Several new procedures have been described recently which are of help to the clinician. The Kep-

ler-Robinson-Power Test²⁴ is regarded as one of the most reliable and has the advantage of little or no danger to the patient. It is based on two primary concepts: (1) that Addisonians excrete excess water more slowly than normals, due to a diminished ability to produce dilute urine; and (2) that Addisonians tend to retain urea and excrete excessive amounts of sodium and chloride.

Thorn^{25, 26} has recently described a test based upon the concept that there is a humoral pathway between the adrenal medulla, the pituitary, and the adrenal cortex. He has shown that the giving of adrenalin intravenously will cause the pituitary to secrete adrenocorticotrophic hormone (ACTH) which in turn stimulates the adrenal cortex. In so doing the steroids thus elaborated depress the circulating eosinophils of blood in normal individuals. If, in the absence of pituitary disease, no depression of the eosinophil count occurs, adrenal insufficiency exists. The use of ACTH eliminates the pituitary factor, if necessary for the differential diagnosis. This test is of distinct benefit to the clinician in segregating patients with true adrenal insufficiency from those with anxiety states.

Other laboratory procedures commonly employed show low plasma sodium and chloride values, high plasma potassium increased blood nonprotein nitrogen and urea, low fasting glucose levels, and diminished 17-ketosteroid output in the urine (50 percent of normal in males and almost nil in females). Insulin tolerances, salt deprivation, and potassium resistance tests are specifically mentioned only to caution of their danger to the patient in that they may precipitate a crisis.

Assuming that a positive diagnosis of Addison's disease has been made, the treatment divides itself into that concerned with maintenance and with crisis. It is always well to consider the general health of the patient, remembering that pulmonary or visceral tuberculosis must be ruled out. As in individuals with diabetes, the presence of infection, acute or chronic, complicates the picture and makes the control and treatment more difficult.

Maintenance therapy concerns itself with the use of desoxycorticosterone acetate (DCA). Thorne²⁷ was the first to evaluate this compound clinically.

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He found that the patient could usually be maintained on the daily intramuscular administration of 3-4 mg. DCA in oil. It was noted that desoxycorticosterone kept the electrolyte balance under control but had no effect on carbohydrate or protein metabolism. Thorn²⁸ later developed a pellet containing the hormone and implanted one 125 mg. pellet in the subcutaneous tissue for each 0.5 mg. required by daily injection. This form of treatment was advantageous in that daily injections were not required; however, it had several distinct disadvantages, namely, that the hospital time plus the laboratory control measures were exceedingly expensive. Another is that excessive salt and water retention may occur, causing elevation of the blood pressure or congestive heart failure, if there is too rapid absorption of the pellets. It has been shown in rats that excessive amounts of desoxycorticosterone with normal sodium chloride intake are capable of producing myocardial necrosis.²⁹ Similar clinical results have been noted to occur with too large an intramuscular injection.

Anderson, Haymaker, and Henderson³⁰ reported the use of linguets, an oral preparation. Buccalettes³¹ in 2-4 mg. daily dosage have been used with some reported success. It must be remembered that, in spite of good sodium and chloride balance, when desoxycorticosterone is used, hypoglycemia may occur. Frequent feedings and a liberal salt diet are also part of the therapeutic regimen.

Obviously the administration of a hormone which only regulates the salt and water metabolism leaves a great deal to be desired for optimal therapy. Testosterone has been given for its gluconeogenic effect. A dose of 30-50 mg. of methyl testosterone in tablet form of 5-10 mg. daily in linguet form may be used. Females with low 17-ketosteroid content in the urine and males who demonstrate hypogonadal function improve with this additional therapy.

As mentioned previously, the treatment of adrenal crisis is virtually the treatment of shock.

Whole adrenal cortical extract is employed in from 20-100 cc. doses, intramuscularly or intravenously, as the emergency demands. Slow infusion of glucose in saline solution, along with plasma or whole blood, and the administration of antibiotics, are lifesaving procedures, though too rapid administration of the infusion may be dangerous. As the patient recovers, DCA is given daily in 5-10 mg. doses, reducing the amount as rapidly as possible to a maintenance level. It is best not to use it during the stage of acute crisis.

Two patients with Addison's disease recently under observation and treatment have forcefully focused my attention upon the possibility of heterologous transplantation of adrenal glands. This method of treatment has been employed in the past, and by virtue of the improvement in modern methods revival is indicated. The cost of natural adrenal extract and of hospitalization for the private patient is almost prohibitive. (This is also true for the charity hospital or clinic.) Replacement therapy leaves much to be desired by the patient and physician. Adrenal transplantation may be the answer.

Loeb³² points out that many attempts have been made to transplant a gland or the cortical cells of a gland from one person to another in the treatment of Addison's disease without much success. He does not recommend the procedure. Grollman³³ in his textbook stresses the importance of further investigative work and feels that it may solve many of the existing therapeutic inadequacies. However, it is important to note that present-day methods of diagnosis, treatment, and control will make an appreciable difference in evaluating the response obtained from transplantation procedures. Katz and Mainzer³⁴ pointed out that only five authentic cases of Addison's disease so treated and adequately followed had been reported in the literature. They were adding a sixth in which a transplant had been successfully made into the abdominal musculature with a 15 month follow-up period of observation.

Thiersch³⁵ reported an ingenious method of intrasternal bone marrow grafting of fetal adrenal tissue with some success. He mentions that a successful procedure may tide an Addisonian over critical periods, thus allowing time for remnants of the affected glands to regain their functional

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ability. Ingle³⁶ and Perla and Gottesman,³⁷ reporting experimentation studies, have shown that the functional behavior of adrenal grafts is similar to that in humans. Dunphy and Keeley³⁸ de-

scribe their technique of autotransplantation in dogs. They demonstrated physiological and biological activity of their transplants.

36. Ingle, D. J.: Resistance of rat to histamine shock after destruction of adrenal medulla, *Am. J. Physiol.*, 1937, cxviii, 57.

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Thus, with this background of experience to draw from, the ingenious surgeon of today is confronted with a new challenge. The effect of such a procedure can undoubtedly be far-reaching in its benefit to humanity, both from the therapeutic and economic viewpoints, if successful.

ISOLATED PARALYSIS OF THE SERRATUS ANTERIOR MUSCLE

CASE REPORT

J. P. GRIFFIN, M.D.

CHESTERTON

THE patient was a white, married female, aged thirty-two, who had been in good health for the past few years. Her chief complaint on her first visit was moderate pain over the right scapula associated with inability to raise her right arm above shoulder level. She said her husband noticed that when she raised her right arm it appeared as though her shoulder blade slipped out of joint. The condition had started slowly and insidiously one month before. There was no history of acute trauma or muscle sprain. Physical examination and laboratory findings were essentially negative, except for the characteristic deformity of winged scapula on the right side.

A diagnosis of paralysis of the right serratus anterior muscle was made. Treatment consisted of bi-weekly injections of Thiamine Chloride (250 mgm.) given intravenously, plus light massage and heat. Because of home conditions it was not feasible to put the shoulder and arm in a splint; instead a sling was advised, and the patient was instructed to keep her arm in the sling for a good part of each day. At the end of two months improvement was noticed. At the end of six months the right scapula was exactly the same as the unaffected side. The patient was able to carry her right arm through a full range of motion without pain.

DISCUSSION

Reported cases of this interesting condition are rare. All in all, as Chandler¹ states, there are less than 250 cases on record. Only 28 cases have been observed by the Mayo Clinic.² The actual incidence may be higher since many cases are transient in nature. All forms of the disease tend to heal spon-

taneously, except those in which the nerve has been severed.

Action of the serratus anterior muscle approximates the scapula to the chest wall and assists in the forward movement of the shoulder girdle. Paralysis of the muscle therefore allows the scapula to assume a winged appearance. Usually the fingers of the examiner can be inserted to a surprising degree between the scapula and the thoracic cage. Serratus anterior action also rotates the scapula, so that the glenoid cavity is raised during elevation of the arm above a horizontal level. Paralysis of the muscle inhibits elevation of the arm because of the inability to rotate the scapula and elevate the glenoid.

Isolated paralysis of the serratus anterior is caused by a malfunction of the posterior thoracic nerve (external respiratory nerve of Bell), which innervates it. The right side is affected at least four times more often than the left. The disease occurs four times as often in men, particularly men in the laboring class, doing arduous work. Soldiers are prone to this disease because of prolonged carrying of heavy knapsacks. When the condition does occur in women, there is often a history of prolonged labor in childbirth before the onset of symptoms. Occasionally the symptoms and signs do not become apparent for several months after the injury, but this is the exception rather than the rule.³

Other causes consist of penetrating wounds, foci of infection, pressure from neoplasm or distended bursa of the shoulder joint, and surgical operations.

In the differential diagnosis one must consider that the case under observation might be an exam-

Figure I



Shoulder girdles in relaxation, showing tendency to right-sided "winged scapula."

(Reprint from article by Fremont Chandler.¹)

Figure II



With arms raised "winged scapula" on right side is more prominent.

(Reprint from article by Fremont Chandler.¹)

ple of a slowly progressive muscle paralysis. This entity is very rare, of course, and probably the only way in which the true nature of the pathology could be ascertained would be to follow the course of the disease.

TREATMENT

Treatment of this unusual condition should be conservative. Most of the cases not involving an actual severance of the nerve will recover completely within three months to three years. Some form of immobilization of the arm with the scapula against the thoracic cage is considered ideal. A shoulder spica, special braces, or even a simple sling, accomplish this end with more or less success. Heat, massage, and heavy doses of B₁ are helpful. Actual electrical stimulation of the muscle is not considered to be worthwhile; Ellis, of St. Luke's Hospital in Chicago, states that more harm than good is attendant on this type of treatment.⁴

Operative interference usually is done, either to make a nerve anastomosis or to make a muscle transplantation. Neither type of surgery has many adherents, nor does the wiring of the scapula to the underlying ribs offer much chance of success.

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Indianapolis Obstetrical and Gynecological Society

FALL MEETING

Speaker

Dr. Edward C. Hughes

Professor of Obstetrics

Syracuse University School of Medicine

Subject

"The Nutritional Value of the Endometrium for Implantation and Habitual Abortion"

PLACE—Indianapolis Athletic Club

TIME—Wednesday, November 16, 1949

6:30 p.m.—Social Hour

7:00 p.m.—Dinner

ALL MEMBERS OF THE MEDICAL PROFESSION CORDIALLY INVITED

Reservations may be made through Sprague H. Gardiner, M.D.,
314 Hume Mansur Building, Indianapolis.

TINEA CAPITIS: A REVIEW OF THE PROBLEM

JOHN C. SLAUGHTER, M.D.

EVANSVILLE

JOHN ERIC DALTON, M.D.

ROBERT E. JENKINS, M.D.*

BOYNTON H. BOOTH, M.D.*

INDIANAPOLIS

THE common and so-called "gray patch" type of ringworm of the scalp has become epidemic in Indiana. The disorder was first reported in epidemic proportion in Indiana in August 1945. Since this early report several representative cities in the state have had a serious epidemic problem. In some of these cities the problem seems under control but it still threatens others. We believe the problem is of serious import and worthy of review with regard to accepted methods of diagnosis, "isolation," and treatment.

EPIDEMIOLOGY

The disorder has been endemic in the larger cities of the United States for over forty or fifty years, occurring mostly in the slums of the large cities, orphan asylums, and among other similar underprivileged classes.¹ Following a severe, early epidemic in Paris in 1906,² the disorder appeared in Eastern Europe and was reported in the medical literature as endemic in New York City as early as 1893. Scattered cases were reported from the large clinics of great metropolitan centers throughout the years, but the disorder never became epidemic until the present one (1942-1948), which apparently originated in New York City in late 1942.³ From this focus the epidemic spread widely throughout the eastern and midwestern states, at first to the large metropolitan areas and then to smaller cities and villages. The spread was not multicentric, that is, from already long established foci in the large cities. There has not been an adequate explanation as to why the infection assumed epidemic proportions. Cultural and other features of the infecting fungus have not changed, in so far as it is possible to determine.¹ The infection is confined mainly to children before puberty, and perhaps the "war born" migrations of families and dependents from one locale to another was a great factor. Much has been written in medical periodicals and the press in recent years regarding the present epidemic. Many of the larger cities have appointed commissions to study the problem and recommend the best means of

controlling the epidemic. Such a group, Lewis, Cipollaro, et al,³ have outlined a plan which we follow closely and which by way of historical interest is quite similar to the recommendations of Fuhs in the Vienna epidemic of 1910.⁴ Certainly the control of an epidemic of ringworm of the scalp requires the cooperation of the medical profession, public health authorities, school administrative and nursing staffs, and physicians qualified to diagnose and treat this stubborn infection.

DIAGNOSIS

The condition is characterized by loosening and partial loss of scalp hair in patches, breaking off of the infected hair, which loses its luster, and inflammation of varying degree. The infection (*M. audouini* type) is almost entirely limited to children under 10 to 12 years of age. The greatest incidence is in ages 4 to 10. It is, therefore, a serious problem in our grade schools and it is in the school system that case-finding can best be accomplished. This can be done simply and accurately by a routine periodic check with the filtered ultra-violet light, commonly known as "Wood's Light." These lamps cause infected hairs to fluoresce a brilliant green color which is very distinctive and not easy to confuse. Several other disorders producing a similar clinical picture are quickly ruled out. Lamps of this type are available at moderate cost, the technique of their use is readily learned, and screening can be done by a school nurse. Under such circumstances of the lamp's use, a tentative diagnosis of scalp ringworm is made. The children should then be sent to a qualified physician who can make a positive diagnosis by means of:

- 1.) Direct microscopic examination of hair with potassium hydroxide solution.
- 2.) Culture on Sabouraud's maltose agar.

Unfortunately this skill is not easy to acquire and special training is necessary. It is important to stress these last two examinations as the specific etiologic fungus cannot be determined by the Wood's light alone—all types of *Microsporum* *tinea capitis* fluoresce the same, and the treatment for these various types is entirely different.

* Department of Dermatology and Syphilology, Indianapolis General Hospital.

CASE REPORT

The following case illustration from our series is an example of our recommended approach to the problem as seen at Indianapolis General Hospital.

W. A., white male, age 10, is sent home from school by the school nurse because of clinical "gray patch" ringworm and positive Wood's light findings. W. A. is brought to our clinic for consultation. Upon examination of the scalp, several round, scaling areas of incomplete alopecia are noted. Wood's light examination reveals many typical greenish fluorescent hairs. Several infected hairs are removed by manual epilation and studied microscopically in a warm 10 percent potassium hydroxide preparation. On examination with ordinary high dry magnification, typical spores of *Microsporum* infection are seen as a sheath around the hair shaft (ectothrix). Additional infected hairs (two to five) are then planted on Sabouraud's maltose agar slants and incubated at room temperature for two to three weeks. All siblings and known close contacts of W. A. are requested to come to the clinic and be checked with the Wood's light, regardless of age.

CONTROL MEASURES

In Indianapolis all Wood's light positive children of school age are required to be absent from school pending accurate diagnosis and cure. Their "relative isolation" at home is advised. In our opinion, there is no justifiable argument against this policy, except, perhaps, where over 50 percent of the school children of a given system are already infected. Children, here, are allowed to return to school only after repeated Wood's light examinations are negative. Certainly the practice of sending infected children to school with "skull caps" is to be condemned. We cooperate actively with the above ruling of the local health authorities, and at the same time explain to the disturbed parents the basis for such a regulation. The efficacy of this regulation, in practice, can readily be seen in the relatively few cases in the Indianapolis school population. In Elkhart, Indiana, with a school population of around 6,000, there were 431 children infected with tinea capitis. This was a serious epidemic, and such a proportion or incidence in Indianapolis would mean around 5,000 cases. Actually, at the time of writing (September 1948), there are less than 100 cases in the school age group—less than one case per school. In our series of cases and from data received from two groups studied in Evansville, the great majority of cases of tinea capitis are caused by *Microsporum audouinii*—about 90 percent. After the accurate diagnosis of audouinii type of infection is made, treatment is outlined and begun.

TREATMENT

Local treatment of the audouinii epidemic type of ringworm has not proved successful. We were unable to duplicate the reported results of Schwartz, et al, of a cure of the majority of cases of tinea capitis with salicylanilide (Salinidol).⁵ Many topical medicaments have been proposed and used, but no one preparation has given satisfactory

results when used in the absence of some form of depilation in epidemic ringworm. The treatment of choice in *Microsporum audouinii* infections is epilation with x-ray, plus local therapy. Roentgen epilation is performed in one sitting and the child may return to school in about two months. The temporary defluvium can easily and safely be produced by a qualified therapist. In experienced hands it requires about 30 minutes to carry out the standard Adamson-Kienbock technique⁶ of five-point x-ray epilation. It is not our purpose to propose specific dosage in view of the many variable factors. However, we do believe that oftentimes dosages used are inadequate and the incomplete epilations that follow are very regrettable. With adequate dosage properly applied, complete defluvium usually occurs in 18 to 21 days. Regrowth usually begins in about 6 to 12 weeks. The only treatment failures we have had in our series of cases to date have been those patients in whom we did not obtain complete defluvium. This is a distinct complication, as a second epilating dose of x-ray cannot safely be given for 6 months. Some failures are occasioned by the technical difficulties involved in treating the younger children in the 3 to 6 year age group, as regards patient cooperation during therapy.

Most dosages used range from 300 to 400 roentgen units. Although there is the potential danger of permanent defluvium, there is a wide margin of safety. At the Columbia-Presbyterian Medical Center, 400 r. unfiltered is used and over 5,000 patients have been epilated without a single mishap.⁷ Spot epilation of single infected patches, at first recommended by Lewis and Hopper,⁸ has now been abandoned by most men. Thallium acetate, previously used in the early 1930's by some men for epilation, has likewise been dropped. Before and after x-ray epilation, we advise local treatment with an anti-parasitic fungicidal ointment. We use ammoniated mercury 5 percent, undecylenic acid, and/or propionic acid. This local treatment is instituted to destroy the few spores which remain on the scalp, and to avoid relapses and reinfection. It must be pointed out that x-ray treatment causes the hair to fall out, but has no direct effect on the fungus except mechanical removal of the completely involved hair bulb and shaft. We advise shampooing the scalp at least every three days and applying the local medicament twice daily. A cure is assured if the epilation is complete and the scalp is rid of clinical evidences of the disease before the regrowth of hair is evident. However, cure is not certain until repeated Wood's light examinations are negative, including such an examination at least two weeks after discontinuation of all local therapy. Following such an examination school age children are returned to school. Children who are clinically negative but Wood's light positive are potential sources of infection and should be isolated and treated as previously outlined. The prognosis in untreated cases of epidemic ringworm is that such cases usually persist

until puberty or after, unless treated by roentgen ray epilation.

SUMMARY

An epidemic of the dry, scaling ringworm of the scalp in children has been present in the United States for six years and is well established in Indiana. This "epidemic" type of scalp ringworm is caused by *Microsporum audouini* and is limited to children under the age of puberty in the majority of cases. It is more common in boys by a ratio of 9 to 1. The disease persists in spite of local treatment and can be cured only by x-ray epilation plus local treatment. The accurate cultural diagnosis of *M. audouini* ringworm infection must be obtained prior to rational treatment. Control of the epidemic is possible only by cooperation of school and health authorities with the medical profession, and particularly with physicians specially trained in diagnosing and treating this stubborn infection. Routine examination of school children and the contacts of infected individuals by means of a Wood's light is advised. Infected hairs fluoresce a brilliant green with such lights and are not easily confused. No Wood's light positive children should be allowed to attend school. Confirmation of the diagnosis culturally and treatment with

temporary roentgen ray epilation should, of course, be done by physicians qualified by training to do such work.

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LETTER TO THE EDITOR

Dear Sir:

The study of twins is of great value in providing information concerning the respective importance of hereditary predisposition and environmental influences in disease in man. The results of the use of this method have shown a hereditary predisposition to tuberculosis, diabetes, and tumor formation, and a high, medium or low intelligence quotient.

There is some *a priori* evidence showing an hereditary predisposition for peptic ulcer. Only six cases of the occurrence of peptic ulcer in the one or both of mono- or dizygous twins have been reported in the readily accessible literature. Since twins are born in 1 of 86 births and identical twins in 1 of 344 births and the general incidence of ulcer is from 5 to 10 percent there should be plenty of material available.

I should like to ask physicians to cooperate in assembling such material by sending me cases in which (1) one or both twins develop peptic ulcer, (2) the site of the ulcer, (3) the age of onset of ulcer, (4) the type of twins (monovular or diovascular), (5) the sex of the twins, (6) the date of birth of the twins, and (7) the number and age of the brothers and sisters and the absence or presence of ulcer in each.

Yours sincerely,

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CHYLOUS ASCITES*

A CASE REPORT

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INDIANAPOLIS

and

RHEY WALKER, II, M.D.

DALLAS, TEXAS

CHYLOUS ASCITES is an interesting condition because of its obscure etiology, infrequent occurrence, and especially because it may simulate and be mistaken for more common medical and surgical disorders.

Various and somewhat confusing classifications of chylous effusions have been made.** Probably the simplest classification is as follows: True chylous effusion in which the milky appearance of the fluid is due to the presence of actual chyle, and pseudochylous effusion in which the opacity of the fluid is largely due to the presence of lecithin and globulin in a finely divided suspension resulting from degeneration of cellular elements. As indicated, both types of effusion are characterized by milky fluid. Another feature is that in neither type will the milky appearance disappear upon centrifugation.¹ However, in true chylous effusions large, fat globules readily stain with Sudan iii and, in addition, the milky fluid readily clears with ether extraction. The latter is a simple procedure. About five cc. of the milky fluid is placed in a test tube. A few drops of ether are then added, the mixture shaken, and almost immediately the ether with the extracted fat floats on top, leaving a clear fluid below this layer.

Excluding parasitic and neoplastic obstruction, or trauma which disrupts the lymphatic system, the etiology in most of these effusions remains obscure.*** Frankenthal, after studying case histories of children with chylous ascites of unknown etiology, postulated that tuberculous glandular tumors of the mesentery or tuberculous peritonitis were the most likely etiological factors.²

CASE REPORT

The patient was a 16 year old white girl who was first seen on March 18, 1948. Her complaints

were shooting pains of twelve hours duration, located in the epigastrium and radiating to the right upper and lower quadrants, accompanied by nausea and anorexia. She stated that she had had a similar episode approximately three months previously. She had been told by her local physician that this was an "attack of appendicitis." In the interim she had felt perfectly well. Her school nurse had told her on the day prior to admission that she had a "little fever." On that day she had experienced frequency of urination. There had been no vomiting, diarrhea, constipation, hematuria, pyuria, or dysuria, but she was in the second day of her four day menstrual period. Past history and family history were noncontributory. There was no family history of tuberculosis.

On physical examination the patient was well developed and well nourished but appeared acutely ill. The blood pressure was 112/78 and the apical rate was 82 per minute. Her temperature was 100° F. Upon percussion of the chest the left diaphragm was found to be high, apparently the result of a distended stomach. This was verified by re-examination after aspiration of the stomach. Otherwise, the head, heart, and lungs were normal. The general contour of the abdomen was flat. No signs of fluid were present. There was generalized abdominal tenderness with maximal tenderness and positive rebound phenomena elicited over McBurney's point. Rovsing's sign was positive. Bowel sounds were normal. A few indiscreet, nontender inguinal nodes were present bilaterally. Pelvic examination revealed a small amount of bleeding from the cervical canal. There was minimal tenderness on manipulation of the cervix, and equivocal tenderness in both adnexae. Rectal examination confirmed the equivocal tenderness noted above.

* From the department of Surgery, Indiana University School of Medicine, Indianapolis.

** The term effusion is often used rather loosely. Effusion may occur by transudation, exudation, or spillage. Transudation occurs as a result of obstruction with no concomitant damage to the containing membrane or endothelial lining. Exudation occurs as a result of damage to the containing membrane or endothelial lining by some process such as inflammation. Spillage also occurs as a result of damage to the containing lining, but in this instance fluid pours out because of a break or hole in the containing membrane.

*** Freeman has shown in dogs that the main lymphatic channels (thoracic duct or right lymphatic duct or both, or the cisterna chyli as well as the lymphaticovenous communications along the system) could be ligated with no accumulation of fluid occurring as the result of the obstruction. He feels that the lymphaticovenous communications are so rich that obstruction of the lymphatics as a cause of chylous ascites is unlikely. He feels that disruption somewhere along the lymphatic chain resulting in spillage would be a more likely factor. This disruption need not necessarily be due to trauma resulting from violence but might occur from erosion of the lacteals or some portion of the lymphatic system producing a spillage.

There were numerous condyloma accuminata in the perineal region.

The initial laboratory data revealed the following: Hemoglobin 12.5 gms., Wbc. 10,650 with 17 percent band forms, 51 percent adult polymorphonuclears, 28 percent lymphocytes, 2 percent monocytes, and 2 percent eosinophils. The urine was negative, except for the presence of many epithelial cells and crystals. Cervical, urethral, and vaginal smears for gonorrhea were negative.

Roentgenographic studies showed no significant abnormality in the pulmonary, cardiac, or mediastinal fields. There was gas in the large bowel with some distention in the region of the cecum and ascending colon, and innumerable collections of gas in the entire small bowel.

It was our impression that the most likely diagnosis was acute appendicitis. Under ether anesthesia a McBurney incision was made, and immediately upon opening the peritoneal cavity, 250-300 cc. of an opalescent fluid having the appearance of homogenized milk was obtained. The cecum was very mobile. It was a striking feature that there was an accumulation of this same fluid beneath the serosa of the lateral wall of the cecum. This was of a pure white color, as if milk had been injected beneath the serosa. The appendix and pelvic organs were normal. No Meckel's diverticulum was found. The mesentery was perfectly normal, only a few apparently normal lymph nodes being present.

The pathologist's examination revealed a "normal appendix and true chyloform ascitic fluid." A smear made at the time of surgery and stained with Sudan iii showed many fat globules. The fat dissolved in ether with clearing of the fluid. The total fat in the fluid was found to be 4.605 gms. percent and the total protein was 6.28 gms. percent.

Other laboratory data obtained were a negative cephalin cholesterol, serum cholesterol of 204 mg. percent, cholesterol esters of 88 mg. percent, thymol turbidity of 7.5 units, and a normal Mosenthal test. The blood Mazzini was negative. Cultures of the peritoneal fluid, as well as those of the stool and urine, were reported as negative for growth, acid-fast bacilli, and parasites. The patient's white count dropped to 6,700 four days postoperatively and on discharge was 5,600. The differential also gradually returned to normal. Second strength Mantoux skin test (0.005 mg. tuberculin, purified protein derivative) was positive.

The patient was discharged from the hospital on the fourteenth hospital day after an uneventful recovery. She was seen on April 19, 1948, and on May 24, 1948, and registered no complaints whatsoever. She returned and was readmitted on June 28, 1948, complaining of nausea, vomiting, and cough of three weeks duration. She also stated she had lost eight pounds in weight, and complained of pain in her back and left flank and weakness in her lower extremity. On examination she was found to be pregnant; this was corroborated by a positive Friedman test. Study of sputa, vomitus, gastric contents, and urine failed to reveal

any acid-fast bacilli. Roentgenograms of the chest, spine, abdomen, intravenous pyelograms, and barium enema revealed no evidence of tuberculosis or any other disease. She was discharged on July 15, 1948, with a diagnosis of uterine pregnancy. She has not returned since.

SUMMARY AND DISCUSSION

Lyter states that in many of these cases it is impossible to determine from a purely chemical standpoint whether an effusion is chylous or not.³ However, as we have pointed out, the nature of the fluid can be established for all practical purposes by Sudan iii stain and ether extraction.

The diagnostic sign of milky fluid beneath the serosa of the intestine substantiates the diagnosis of chylous ascites. To arrive subserously, the fluid would have to be lymphogenous in origin. Possibly the etiology in our case was intestinal tuberculosis of bovine origin, but certainly no adequate substantiating evidence was found.

It is interesting to note in reviewing the literature that many of these cases present the picture of an acute abdominal condition. Frankenthal's case was clinically similar to ours, in that tenderness was most marked at McBurney's point prior to exploration.⁴

Wyatt and Gross report that a distinction can be made between ascitic and chylous fluids radiographically by comparing the density of the liver shadow with the surrounding fluid.⁵ Chylous fluid is less dense than ordinary types of ascitic fluid, therefore less dense than the liver shadow. A flat plate of the abdomen in our case failed to reveal this finding.

As was commonly experienced by others, we failed to make an exact preoperative diagnosis but did note at operation the typical fluid which under direct smear showed fat globules and no bacteria.⁵ It is our feeling that, in most instances, chylous fluid can be differentiated from purulent fluid at the time of operation.

Most cases reported have been of massive ascites, in which the constant accumulation of fluid was a problem. We feel that in cases such as ours, in which the fluid present is minimal and probably transitory, that the peritoneal cavity should not be drained. Drainage would only invite infection, loss of fluids, loss of electrolytes, and loss of protein.

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THE JOURNAL

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THE JOURNAL'S PLATFORM

1. Preservation of American Medicine through voluntary service to the sick.
2. Advocating full-time county or district health officers, locally appointed.
3. Restoration and preservation of our natural waters and resources.
4. Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.
5. Elimination of diphtheria and smallpox through immunization and vaccination.
6. Support of the state-wide campaign against undulant fever.

VOLUNTARY HEALTH INSURANCE

THE development and expansion of voluntary medical insurance has always been recognized as the most potent weapon available against compulsory medical insurance and socialized medicine.

By encouraging the growth of all types of voluntary plans, both commercial and nonprofit, the medical profession has proved to the people that the costs of catastrophic illness can be met on a budget basis, without the intervention of a government bureau.

As the voluntary plans increase the number of families under their protection, the number of citizens who may be susceptible to socialist propaganda correspondingly decreases.

While the movement toward compulsory health insurance and socialized medicine has not been defeated, and even though an alert and active educational campaign will probably be necessary for many years, it is encouraging to review the growth and to admire the strength and popularity of the voluntary system.

Michigan Medical Service, the Blue Shield plan for the state of Michigan, was one of the first physician-sponsored programs. It began operations in 1940 and was the first plan to enroll one million members. On March 31 of this year it had 1,329,044 subscribers; one of every five residents of Michigan is protected. During 1948 its growth amounted to over 375,000 persons.

The Blue Shield Plan for the state of Connecticut recently announced the data for its first six months of existence: 141,000 persons, or approximately 7 percent of the entire population of the state, were enrolled during its initial half-year.

Mutual Medical Insurance, our own Doctors' Plan, is now completing its third year. It enjoyed an increase of enrollment amounting to 8.61 percent during the first three months of 1949, and at the end of July 311,079 persons were under its protection. It has just completed a community enrollment in Evansville which added approximately

30,000 subscribers. This is the largest community in the country to be enrolled in this manner.

Mutual Medical is now conducting two or three community enrollments each month, and is working toward a goal of 400,000 members by the end of this year. The impetus for many of the community enrollments has been furnished by members of the medical profession.

The Doctors' Plan has recently announced a new individual contract, to be known as the Health Statement Contract. This is a progressive step, and will greatly widen the field of insurable individuals who are eligible for Blue Shield coverage.

While the growth of voluntary medical insurance during the past ten years has been tremendous, there are those among the advocates of compulsory insurance who attempt to find fault with it, on the ground that it does not cover everyone at the present time. In answer to these critics it may be said that the voluntary system has grown steadily, and has remained financially sound. The pioneer plans have developed actuarial data and management principles in an entirely new field. Much harm could have been done if the system had developed too quickly, and had favored spectacular growth, to the detriment of financial soundness.

It is heartening to observe that, in the midst of an avalanche of government propaganda for compulsory medical insurance, the voluntary plans have thrived. Each individual and each family which is added to the millions who enjoy voluntary insurance reduces by just that much the number of persons who are susceptible to the socializer's wiles.

INDIANA DIABETES SURVEY

ANNOUNCEMENT is made by the Committee on Diabetes of the state association of plans for the amplification of Diabetes Detection Week, as sponsored by the American Diabetes Association, into an Indiana Diabetes Survey to be conducted during this month, on a state-wide basis.

Community surveys in the past, in which almost 100 percent of the citizens of one locality have been studied diagnostically for diabetes, have shown that there are approximately as many unknown diabetics as there are known ones. The best kind of diabetes to have is the kind which is discovered early in its course. The results of good diabetic management in such cases tends to minimize the severity of the disease. It also does much to prevent and delay the development of complications. The medical profession can render a splendid service to the public, by aiding in the early diagnosis of diabetes mellitus and thereby enabling its early treatment.

An effort is being made to interest as many people in the survey as is possible. The larger the proportion of the population tested, the greater will be the number of diabetics uncovered. Since it is known that a large number of "unknown" diabetics are relatives of known diabetics and are usually overweight, a special effort is being made to survey families of known diabetics, and to include as many overweight individuals in the study as is feasible.

Many of the county medical societies have developed plans for the survey during the summer months and have arranged for widespread publicity concerning the details of the study. The State Committee on Diabetes has arranged for the distribution of informational material from the American Diabetes Association. Reagents for urinalysis are available without charge. The program has the approval of the A.M.A. and the Indiana State Medical Association, and should receive the interest and active support of many other public-spirited organizations.

An energetically conducted public campaign such as this will be a good tonic for medical public relations. Since it is being held immediately after the Centennial Meeting of the state association, it may be said to be an excellent undertaking on our part for the launching of the second century of free medicine in Indiana.

Editorial Notes

The Veterans of Foreign Wars at their Annual Encampment in Miami, Florida, this year adopted an especially strong resolution against Compulsory Health Insurance. The convention which unanimously passed the resolution represents over 1,500,000 veterans. Indiana was one of six states mentioned particularly by Whitaker and Baxter as having been of assistance in securing this national action.

Recently *The Detroit News* conducted a poll to determine the popular opinion of several national problems which are being debated by the Congress. One of the questions asked was whether the person interviewed favored national health insurance. The final vote was on a proportion of twelve to one against national health insurance. This can be considered to be especially significant, since Detroit is a large industrial center and since the advocates of compulsory health insurance have been claiming that the large industrial centers were the parts of the country which needed and wanted this type of insurance the most.

Consumers Research published a straight-talking and down-to-earth editorial on compulsory health insurance in the September 1949 issue of their Bulletin. By applying methods of analyzing advertising claims and sales literature to the propaganda which has been spread for National Health Insurance, the editors have developed an analysis of the "product" which is distinctly different. The advice which is presented to the consumer as a result of this analysis is as definite and convincing as that which is offered for the articles of commerce which CR usually studies.

Progress in life conservation has been proceeding at so rapid a pace in our country that the gains achieved are very impressive even if measured from so recent a date as 1940. Well over one quarter of a million lives were saved in 1947 alone because of the improvement in mortality since 1940. *Metropolitan Life Insurance Company Statistical Bulletin.*

During the first six months of operation just finished, Connecticut Medical Service (The Doctors' Plan of Connecticut) attained a membership of 141,000 persons, or approximately 7 percent of the state's population. This is a national record for growth among professionally-sponsored nonprofit medical service plans, and indicates the extent of the popular demand for voluntary health insurance.

The state of Texas has been convinced for some time of the necessity of enlarging its facilities for medical education. The recent state Legislature debated three separate bills, each designed to establish a new school of medicine or enlarge an existing school. Since three different cities were concerned, the Texas lawmakers were unable to make a decision as to location of the school. They accordingly amended one of the bills to create the House of Delegates of the Texas State Medical Association as a committee to survey the possible sites for the school and to make a recommendation to the University of Texas regarding their choice of location.

As a result of this cooperative spirit the University of Texas is acquiring the properties and facilities of the Southwestern Medical College at Dallas, and will operate it as a new medical branch. Increase in the enrollment of the school will take effect this year.

"The army of persons who urge greater centralization of Government authority are really more dangerous to our form of Government than any external threat that can possibly be arrayed against us."

—Dwight D. Eisenhower

Final tabulation of births and maternal deaths for 1947 by the National Office of Vital Statistics is graphic proof that medicine under free enterprise is giving the American people the finest health care and the highest level of health of any major nation.

Births and maternal deaths for 1947 indicate a new record low maternal mortality rate of 1.3 per thousand live births in the U. S.—the lowest reported by any nation and a 79 percent reduction since 1933, when the rate of 6.2 placed the U. S. eleventh among leading nations.—*Journal Oklahoma State Medical Association.*

During the years near 1933, there was much criticism of our maternal mortality rate, just at the time when the Committee on Cost of Medical Care began to be heard. It is gratifying to see what has been accomplished by concentrated effort on the part of the profession, sparked by its own members especially interested in the problem.

The recent passing of Dr. Ray Lyman Wilbur brings to mind an editorial in THE JOURNAL of July 1929. In that year Doctor Wilbur was president of Stanford University and was Secretary of the Interior in Herbert Hoover's cabinet. He was past president of the American Medical Association, and in 1929 wrote an article on "Medical Progress In An Economic World."

Dr. A. E. Bulson, at that time Editor of THE JOURNAL, commented editorially on Doctor Wilbur's economic views in relation to medicine. It is surprising how much similarity there is between Doctor Wilbur's thoughts on the subject and the views which have since then become almost universal among the medical profession. At that time Doctor Wilbur pointed out that the cost of medical care was increasing, but that the portion of the cost which was paid the physician was actually decreasing. He felt at that time that even though the doctors were receiving a decreasing proportion of the medical dollar, it was their duty to make plans of some kind which would enable people effectively to meet their medical costs.



President's Page



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To all who made—

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Medical Panorama by the ASSOCIATE EDITOR

THE ENGLISH OCTOPUS

The Journal of the Oklahoma State Medical Association has a "president's page" a good deal like ours. In the August, 1949, number, their president, Dr. George H. Garrison, has the following to say:

"How fast can a country travel toward complete governmental domination of its people?

"This question was answered by Mr. Cecil Palmer of England addressing the Conference of Presidents and Other Officers of State Medical Associations in Atlantic City at the recent meeting of the American Medical Association.

"England's Minister of Health promised openly that under governmental medicine the physician-patient relationship never would be violated. Yet within three weeks after passage of Health Legislation creating socialized, governmentally controlled or political medicine he issued 'Statutory Instrument No. 506' which provided that the terms of service require that a physician keep a record of the diagnosis and treatment of every patient and make these records available to the LAY MEDICAL COUNCIL. There is gone privileged communication.

"What is a Statutory Instrument?

"It is a regulation, edict, executive order—in effect a law set forth by one in high governmental authority which cannot be challenged in the courts. Already there were 505 Statutory Instruments in effect in England before this one dealing with the physician-patient relationship, and not one of them is subject to judicial review!

"Another law which came into being recently in England and shows further evidence of the rapidity with which all rights and liberties can be usurped was designated the 'Control of Engagements Order.' The Control of Engagements Order provided that men and women, 18 to 50 years, may be directed to take a job anywhere, any time, according to the State's choice. What is this except peacetime conscription?

"Let us become aroused by the encircling tentacles of this giant octopus and let us in turn arouse the public.

"Now is the time!"

HOT POTATOES

We noticed this choice bit in the editorial columns of *The Journal of the Oklahoma State Medical Association*, and we hasten to pass it along. Praise the Lord, and pass the ammuni—,—beg pardon, the potatoes:

"The politicians with potatoes in their paunches and in their portfolios didn't know what punches they were pulling when they put potatoes in politics.

"Pulling \$2,000,000 annually out of the people's pockets to pay potato planters parity-plus pyramids the popular price, impoverishes the dinner pot and pauperizes the general population in favor of the potato plutocrats.

"It requires 1,000,000 common people paying an income tax of \$200 to pacify the 28,444 potato planters. The downtrodden planters in Rhode Island un-

loaded enough potatoes on the taxpayers to average \$23,206 per grower. In Massachusetts \$12,229, in Maine \$9,825, in New York \$13,169 and so on down the line.

"The wisdom of our government is beyond finding out.

"Apparently having demonstrated their expertness in the handling of potatoes the bureaucrats are ready to take on the physicians. Compared to the cost of socialized medicine, everything else can be counted as small potatoes."

Incidentally, we are inclined to believe the sum quoted is in error and should be nearer \$200,000,000. But you get the general idea, regardless of that.

FIREWORKS IN IOWA

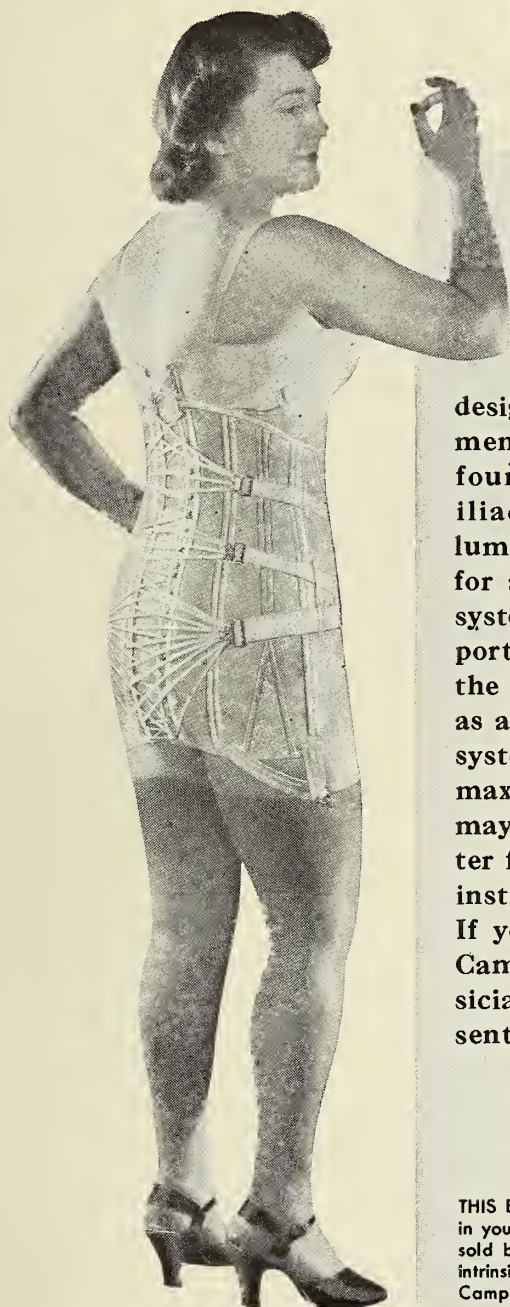
That the House of Delegates of our own I.S.M.A. is not the only body where doctors get up on their hind legs and holler is evident from the following item in the minutes of a meeting of the House of Delegates of the Iowa State Medical Society as reported in their *Journal* (report of Committee on Medical Education and Hospitals):

"**Suggestions to the Legislature.** If our government's and Mr. Ewing's contentions are correct, that we are short of doctors, then our universities must assume some of the responsibility for not admitting larger classes—why not graduate 90 instead of admitting 90? They tell us that appropriations and facilities are not adequate; then the answer is for our legislative bodies to appropriate sufficient funds to expand the facilities for the purpose of medical education, and to see that the money thus appropriated is used for that specific purpose. It is time for the people to realize the medical profession is being made a political football, and the cause of these ills is not the doctor but the people who regulate his training and appropriate the money for that purpose. We resent men elected or appointed to political position who call our profession a "closed shop." The public needs to know that the American Medical Association has no control over our lives or any of the other 142,000 doctors. We are not governed or dictated to as so many politicians would lead the public to believe.

"It is remarkable to note that many leading legislators in our state discuss our need for doctors and the rural need for better medical care, but these same men fall under the old adage, 'They can't see the forest for the trees.' They call upon our Medical School to increase the enrollment and at the same time forget the cost involved. They insist that the superintendent and our dean serve them a dollar meal, and a good one with all the trimmings, but allow them just \$.65 to do this. After all, gentlemen—let's ask the legislators and the public to be fair. If they are, then I am sure our profession will do its part."

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ATOMIC ENERGY COMMISSION REPORT*

THE main content of the 6th Semiannual Report of the AEC to Congress is a progress report on work in biology and medicine. I shall try briefly to evaluate the various fields of interest in biology and medicine as related to atomic energy, to present where we are today, and to point out the next steps in development of this part of the national atomic energy program.

The work described in this report represents only a small part of the large body of knowledge which we are certain will result from these studies. Such studies probably will require from five to ten years or longer for full fruition. I am already looking forward to the Semiannual Reports of 1960 and the accomplishments in the biological and medical fields we then will be able to present.

There are some parts of the present report which I believe are worthy of special emphasis.

DEVELOPMENT OF TESTS FOR RADIATION SICKNESS

Many of the projects which we look upon as studies of peacetime applications of atomic energy may actually be of great significance in the military and civil defense fields. For example, Dr. Rubin Kahn is conducting research at the University of Michigan on changes in certain blood constituents as a result of radiation. This and similar work could have widespread application as a routine screening test for individuals exposed to radiation from atomic weapons. Since the material for this report was assembled, we have learned of other encouraging signs of progress in this regard. Physicians at Bowman Gray School of Medicine, Winston-Salem, North Carolina, have found that animals receiving radioactive phosphorus in studies of nutrition often show subtle changes in liver function. If we are able to work out a simple liver function test it would prove of enormous value in the event of an atomic disaster. Other scientists working on Commission-supported projects have recently shown that patients receiving very large doses of radioactive iodine for treatment of thyroid cancers often excrete considerable amounts of blood pigment. These pigments cause a red fluorescence in a test tube and are simple to detect. These preliminary results indicate that we may eventually have simple tests for detection of radiation injury.

TREATMENT FOR RADIATION SICKNESS

In the treatment of radiation sickness, doctors are now at a relative point of progress similar to the stage which existed fifty or more years ago in

the treatment of many other common diseases. At that time individual symptoms were treated. In the succeeding years, as these common diseases were better understood and the causes and interrelations of the symptoms became clearer, treatments were aimed at the root of the problems and thus became more basic and effective. Today in radiation sickness we are in the pioneering position of treating symptoms while intensively seeking the root of the problem. The results in treating signs and symptoms are quite encouraging.

Our present studies, however, demonstrate the need for continuing work in bone marrow and blood. They point out the need for repeated blood transfusions in exposed individuals and suggest that new substances such as vitamin B-12, which stimulate the formation of mature blood cells, will be of assistance in this regard. They also demonstrate the necessity for maintaining nutrition at highest possible levels. The damage to the bowels prevents absorption of food. It must therefore be supplied by the veins or through the soft tissues and should include protein and carbohydrates, vitamins, potassium, and liberal amounts of salt.

These studies indicate the need, as a civilian defense measure, for adequate laboratory facilities to study the chemical content of the blood in exposed individuals and the great importance of blood and plasma.

Work on the incidence of infection in animals exposed to radiation verifies the need for prophylactic administration of antibiotics, and one would expect that for this the new agents such as aureomycin, chloromycetin, penicillin and others would be valuable. These signs of progress in treatment of radiation sickness are encouraging, but they point out the need for continuation of such research and the need for careful planning for treatment of civilian casualties of atomic warfare.

LONG TERM RADIATION EFFECTS

The immediate effects of an atomic explosion are not our only concern. The Sixth Report tells of the work of the Atomic Casualty Commission in Japan. We believe that from this work we will acquire much needed information as to the long-term effects of an atomic explosion. There is evidence of a return of fertility following a period of sterility. The grossly deforming scars, which have been pictured so extensively, have softened and shrunk with the passage of time. But there is still much to learn. For instance, does the arrest of bone growth shown by many children result from atomic radiation or inadequate nutrition? We cannot expect to learn about the genetic effects of exposure for at least three generations or for 25 years or longer. These studies will be continued. A member of our Division is leaving for Japan next week

* Statement by Dr. Shields Warren, Director, Division of Biology and Medicine, United States Atomic Energy Commission, at press conference on medicine and biology portions of the AEC's 6th semiannual report to Congress, August 4, 1949.



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to review the present status of the program and to participate in planning for future activities.

RADIOISOTOPES IN TREATMENT AND DIAGNOSIS

The Commission last week announced the third anniversary of the distribution to scientists in many fields throughout the United States and in many foreign countries of radioisotopes for research purposes. In this relatively short time the amount of new knowledge that has been gathered in biology and medicine is amazing. Hundreds of papers have appeared announcing these results in all types of scientific and technical journals, including the medical journals. Three years ago we assumed that the Commission would have to support a great part of this research. This has not been necessary. The Commission has found that it has simply to produce the isotopes. The research workers, clinics, laboratories and hospitals need no encouragement to put them to work.

I wish particularly to stress the use of radioisotopes in diagnostic work in the medical field. We are pressing our studies on the localization of compounds in cancers to determine their possible use as a method for detecting cancer and for treating it. Recently published work on location of brain tumors is an example of this. Radioisotopes are already offering a convenient and precise tool for study of bodily functions such as heart action and the competency of the liver. A liver test de-

veloped at the University of California School of Medicine uses radioactive sulfur-labeled amino acids. In patients with liver disease the conversion of these amino acids into protein does not proceed at as rapid a rate as in healthy patients.

PERMISSIBLE LIMITS OF EXPOSURE

The peacetime applications of atomic energy cannot progress without a continually increasing knowledge of radiation as it affects human beings. Ever since scientists first learned that radiation could injure cells and tissue, doctors have attempted to find a permissible limit for continuous exposure. Many standards have been proposed during the years. The International standard permits an exposure of 0.2 units per day. In this country the National Committee for Radiation Protection established a permissible level of 0.1 unit per day. During the war the Manhattan District and more recently the Atomic Energy Commission established 0.1 unit as its maximum permissible exposure for workers. Theoretically, this allowed a safety factor of 10. It was believed that up to 1 unit per day would not cause damage. Recent research conducted in animals under the program of the Division of Biology and Medicine has revealed that under some conditions the 1 unit level causes decrease in fertility and produces tumors. Accordingly, the National Committee will shortly reduce the permissible level to 0.3 units per week, and the Commission has also established this upper limit for day-in-day-out exposure.

ANESTHETICS FOR THE ASTHMATIC

It seems well established that people suffering from allergies, and especially asthma, are more susceptible to anesthetics than other persons. Richard E. Brennan, M.D., Chief of Anesthesiology of St. Joseph's Hospital, Reading, Pennsylvania, says in the July-August issue of the *Annals of Allergy*, the official publication of the American College of Allergists, that the success of anesthesia in the allergic patient depends upon proper planning or proper selection of the drugs to be used. The critical time usually comes after the operation is over. Strict care must be given at this time, he stresses.

Very few cases of allergy to the commonly used inhalation anesthetics have ever been reported. But with the newer drugs and the injectable anesthetics, the story is different. With this much depends upon the skill of the anesthetist. He should always be given a chance to study the patient before the operation so that he can intelligently study the proper drugs. Not infrequently it may be necessary to select a second choice of anesthetic agent or procedure, rather than the original choice, because of this complication in the situation.



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The Fourth Estate Looks At Medicine

This is a newly created section of THE JOURNAL which is to be devoted to the presentation of views and opinions of interest to the medical profession, as taken from the editorial pages of the public press. Its function will be to review for the profession editorial comments both favorable and unfavorable to medicine. To quote the immortal poet Robert Burns:

*"Oh wad some power the giftie gie us
To see oursel's as others see us!"*

Members of the association are invited to submit editorial clippings for inclusion in this section.

MEDICAL PROBLEM MUST BE RESOLVED

The heated opposition to national health insurance and to socialized medicine in any form on the part of doctors, organizations and other groups has considerable merit in fact; however just opposing the national health insurance program will not solve the very real existing difficulties. Medical associations, doctors, dentists, and other groups must take some positive constructive action to insure adequate medical care to all persons who need it.

Government medicine is not a desirable thing. It would be a costly program, and the cost of that program would be borne by every citizen on an inequitable basis. In addition, it would discourage the individual initiative which is a basic part of our way of life. The public reaction to the so-called "free" services in Great Britain has created there an abnormal condition. Everyone rushes to the doctor whether he actually needs help or not, and the burden has become tremendous. The demand for eye-glasses in England is one example. Before socialized medicine was introduced, the average demand for spectacles was five million pairs a year. Today it is 7.8 million pairs. A similar situation exists in all forms of medical treatment.

While the disadvantages of any form of socialized medicine or health insurance far outweigh its advantages, the cry of "socialism" or mere vociferous opposition is not going to correct the medical conditions which do need changing.

In every community throughout the nation there are certain persons who need medical care or treatment and who do not get it because they cannot afford to pay the costs. These people and all people deserve the opportunity to receive adequate medical care. The American Medical Association, through its thousands of doctors and all interested groups would do well therefore to initiate a positive program to insure proper treatment for all.

Stress should be placed on preventive measures—the various steps that people can take to ward off ill health and its subsequent financial load. Participation in voluntary health insurance programs should be encouraged. Enrollment in medical schools should not be limited—every student who desires to become a doctor and who passes the required standards should have an opportunity to go through medical school. Additional medical schools should be established so that the need for

additional doctors can be fulfilled. Perhaps a free medical clinic could be established in each county to care for those whose financial condition is such that it is legitimately impossible for them to afford proper medical care.

The AMA through its thousands of doctor members has the facilities to do many things which will eliminate the criticism of our present medical system. By so doing, it will also eliminate completely the need or the desire for any form of socialized medicine or health insurance.

Medical care in the United States is the best in the world, which indicates that the medical profession has performed and is performing a highly creditable job of inestimable value to every human being. A few necessary progressive changes on the part of the AMA and a slightly broader outlook will make everyone more fully conscious of the benefits of our present medical system.

—Logansport Pharos-Tribune

SOCIAL MEDICINE BALKED

President Truman's plans for compulsory health insurance defeated his Reorganization Plan No. 1, which would have created a Cabinet-status Department of Welfare.

The Senate voted down the plan, 60 to 32, largely because Senators distrusted Oscar Ewing, whom Mr. Truman had in mind to head the new department.

Ewing has been the foremost advocate of the compulsory health insurance program which many believe would be a step toward socialized medicine. As welfare secretary, he would have presided over the government's welfare, education and public health work, all of which would be combined in the new department.

It would have given Ewing a strategic position from which to direct the federalization of the medical profession.

The Senate well understood that the American people are skeptical about socialized medicine, for it is one of the cornerstones of a welfare state.

And Democrats joined with Republicans to block the plan. Twenty-three Democratic Senators voted against it.

—Kokomo Tribune

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Active Ingredient: Mineral Oil 65%.

DIRECTIONS: Adults, one tablespoonful. Children over six years old; one teaspoonful. May be thinned with water, milk or fruit juice if desired.

CAUTION: To be taken only at bedtime. Do not use at any other time or administer to infants, except upon the advice of a physician.

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INDIANA DIABETES SURVEY

October 10 to 16, 1949

A state-wide diabetes survey will be conducted by the doctors of Indiana during the month of October. Plans have been formulated by the Committee on Diabetes of the state association to make the survey as inclusive as possible. The object of the study is the detection of "unknown" diabetics.

The American Diabetes Association sponsors a "Diabetes Detection Week" each year. The Indiana survey will begin early in October and will culminate during the nationally observed detection week, October 10 to 16, inclusive. The remainder of the month will be utilized for completing and rounding out the investigation.

An ADA information kit has been furnished to each county medical society in the state. Due to the fact that local conditions and the means for conducting the survey will vary from locality to locality, your committee is not recommending any set plan, but feels that the details may best be determined by the local committees.

This is a public service to the people of Indiana. Its success will be measured by the number of undiagnosed diabetics which the survey is able to discover. This number will be proportional to the number of people who are informed of the survey and who are influenced to take part. The county medical societies are urged to enlist the help of other public-spirited organizations, such as churches, schools, parent-teacher organizations and clubs.

Industrial organizations and employers should be requested to give publicity to the venture, and may be of assistance in the actual mechanics of the investigation. Newspaper and radio publicity should be obtained if possible. Members of the county society Woman's Auxiliary can be of assistance.

At the conclusion of the survey the Committee on Diabetes requests that each county society report concerning the number of urine specimens examined and the number of previously undiagnosed diabetics discovered.

Coming as it does at a time when the campaign for government control of medicine is at its height, it is significant that the diabetes survey is being planned and managed by doctors of Indiana, working in a free system of medicine, and without government subsidy or control.

The survey should be conducted in such a way as to prove that there is nothing that the government can accomplish in medical service that the people cannot do better for themselves.

Prepared by the Committee on Diabetes
Indiana State Medical Association

Good Nutrition..



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The sound and wholesome nutritious diet is an integral part of modern day preventive and definitive therapy. A steady stream of adequate amounts of all the essential nutritional elements is vital for good growth, maintenance of tissue structure and functioning, healing after trauma, and resistance to infection. For maintaining this daily, steady stream of nutrients, however, conditions both in health and illness often make imperative the use of an efficient food supplement along with the diet.

The *multiple dietary food supplement* Ovaltine in milk has wide usefulness for enhancing to full adequacy even nutritionally poor diets. Its rich store of vita-

mins and minerals includes vitamins A and D, ascorbic acid, thiamine, riboflavin and niacin, and calcium, iron and phosphorus. Its nutritionally complete protein has excellent biologic rating.

Since these vital nutritional values along with carbohydrate and easily emulsifiable milk fat are incorporated in liquid suspension or solution, Ovaltine in milk is also especially adapted to liquid diets. The highly satisfying flavor makes for its ready acceptability when foods are often distasteful.

The important overall nutrient contribution of three glassfuls of Ovaltine mixed with milk is presented in the accompanying table.

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PROTEIN	32 Gm.	VITAMIN B1	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



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News Notes

Dr. C. B. Bohner, of Indianapolis, has been elected president-elect of the Ohio Valley Allergy Society. He will take office as president in 1950.

Dr. Merrill T. Benoit, formerly of Lockport, New York, has taken a position as plant physician at the Delco-Remy Division of General Motors at Anderson. He will assist Dr. Richard Swan, plant medical director. Doctor Benoit served in the Army for two years during World War II.

Formerly of Indianapolis, Dr. Davis W. Ellis has opened an office for the general practice of medicine in Rushville.

Dr. Duke E. Hanna, Jr., has opened an office for the general practice of medicine at Red Key. A 1946 graduate of the Indiana University School of Medicine, Doctor Hanna interned at Indianapolis General Hospital until 1947, when he entered the medical corps of the Navy.

A 1946 graduate of the Indiana University School of Medicine, Dr. James E. Hull has opened an office for the practice of medicine and surgery in Wolcott. Dr. Hull spent his internship at Indianapolis General Hospital, and then entered the U. S. Navy, from which he was recently discharged.

Announcement was made recently of the appointment of Dr. H. K. Lemon, of Goshen, as staff physician at the Logansport State Hospital.

Captain Harold E. List has informed THE JOURNAL office that he is now assigned as Staff Medical Officer to the Naval Air Reserve Training Command, U. S. Naval Air Station, at Glenview, Illinois.

Dr. Paul W. Steele, of Oakland City, has opened an office for the practice of surgery at 629½ Main Street, in Evansville. He recently completed five years of surgical training at Indianapolis General and Veterans Hospitals. Doctor Steele is a graduate of Indiana University School of Medicine, and served for fifteen months with the Medical Corps.

Dr. Paul D. Williams was recently appointed superintendent of the Richmond State Hospital by Governor Schricker. This appointment fills the vacancy in that capacity created by the death in June of Dr. A. W. Snedeker. Doctor Williams previously served as superintendent of the Richmond Hospital from April 1942 until October 1945.

Dr. Gerald W. Gustafson, of Indianapolis, will assist in the presentation of obstetrical and gynecological procedures to be televised at the Lewis Memorial Hospital, Chicago, October 24 to 29, inclusive. The graduate teaching program will feature television demonstrations of deliveries and operative procedures. It will be directed by Dr. Herbert E. Schmitz of Stritch School of Medicine of Loyola University, and will be open to members of the medical profession without charge. One hundred fifty physicians may be accommodated.

Dr. L. E. Burney, Secretary of the Indiana State Board of Health, has received notice of his acceptance by the Board of Preventive Medicine and Public Health for certification as one of the approximately two hundred charter members.

Dr. Robert H. Wagoner of Colburn was the guest of honor at a party given in his honor on August 21. He is retiring after forty-six years of serving the community of Colburn and vicinity. He will be succeeded by Dr. John Wagoner, who recently completed his internship at St. Elizabeth Hospital in Lafayette.

Dr. H. G. Kobrak, of Gary, has returned from Europe where he attended the Fourth International Congress of Otolaryngology, held in London from July 18 to July 23. He presented a moving picture film on "The Function of the Ear in Health and Disease" to the Congress. Following the meeting Doctor Kobrak visited Cambridge, Amsterdam, Frankfurt and Heidelberg, where he addressed a regional meeting of German otolaryngologists. Doctor Kobrak is a member of the Lake County Medical Society, and is an Associate Professor of Otolaryngology at the University of Chicago.

Governor Henry F. Schricker recently announced the reappointment of the following: Dr. J. V. Pace as superintendent of the Southern Indiana Tuberculosis Hospital at New Albany; Dr. Robert A. Staff, superintendent of Indiana State Sanatorium, Rockville; and Dr. W. C. Van Nuys, superintendent of the Indiana Village for Epileptics, at New Castle.

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The American Association for the Advancement of Science will hold its 116th meeting this year at New York City, December 26-31. Four sessions of papers on research in medicine will be held at the Statler Hotel on December 28 and 29. All physicians are invited to attend. The registration fee for members of the AAAS is \$2.00, for nonmembers \$3.00.

The American College of Chest Physicians has announced a Postgraduate Course in Diseases of the Chest, November 14-18, 1949, at the Hotel New Yorker, New York City. The registration fee is \$50.00, and the number of registrants for the course is limited. Applications should be made to the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10.

The Third Inter-American Congress of Radiology will be held at the Hotel Crillon in Santiago, Chile, November 11-17, 1949. Further information regarding the meeting may be obtained by writing to the headquarters, 55 East Washington Street, Room 1421, Chicago 2.

UROLOGY AWARD

The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Washington, D. C., May 29-June 1, 1950.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before February 20, 1950.

NATIONAL SERVICE LIFE INSURANCE SPECIAL DIVIDEND PAYMENT

Veterans of World War II are reminded that the first national service life insurance dividend payment will be made within the next few months. The dividend is paid to the holders of all policies which were in force for three months or more, whether they are in force at the present time or not. In cases where the insured has died, payment will be made to the beneficiary. Dividends will be paid only after application is made. Application forms may be obtained in any post office, VA office or accredited veterans organizations.

The Central Society for Clinical Research will meet at the Drake Hotel, in Chicago, November 4 and 5, 1949.

The Association of American Physicians and Surgeons will hold a two-day meeting October 28 and 29 at the Book-Cadillac Hotel in Detroit. The program will be devoted to the nonmedical aspects of medical practice. Speakers will include the Honorable Herbert R. O'Connor, United States Senator from Maryland, who will discuss S-1456; Dr. R. B. Robins, Democratic National Committeeman from Arkansas, who will speak on "The Doctor's Responsibility as a Citizen"; and Dr. James L. Doenges, of Anderson, who will describe how a typical county medical society (Madison, Indiana) is winning its fight against socialized medicine. A registration fee of \$7.50 includes the charge for the annual banquet. For further information, address AAPS, 360 N. Michigan Avenue, Chicago 1.

The National Society for the Prevention of Blindness will hold a five-day conference in conjunction with the Interim Session of the Pan-American Association of Ophthalmology, March 26-30, 1950, at the Floridian Hotel, Miami Beach, Florida. The theme of the meeting will be "The Americas Unite to Save Sight," and among the subjects to be discussed are: Current blindness prevention programs in countries of the Western Hemisphere; Trachoma; Industrial ophthalmology; Eye problems of school children; Medical and social management of the glaucomas.

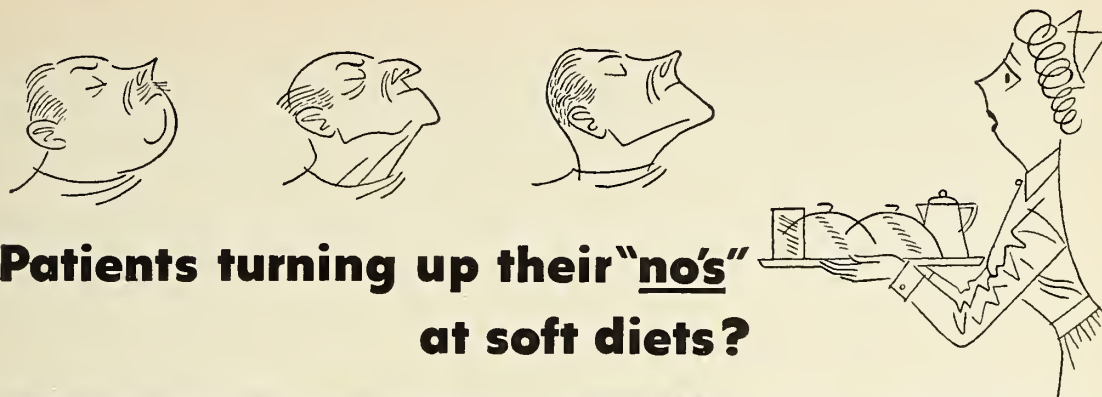
Persons directly or indirectly concerned with eye health and safety will find this conference of interest. Details concerning the program may be obtained by writing directly to the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Reservations should be made in the near future with the Floridian Hotel, 540 West Avenue, Miami Beach, Florida.

POSTGRADUATE COURSE ON URINARY TRACT DISORDERS

On November 17, 18, and 19 the Frank E. Bunts Institute and the Cleveland Clinic will present a continuation course for physicians on "Medical and Surgical Disorders of the Urinary Tract." Dr. Herman L. Kretschmer of Chicago will give the evening address November 17 on "Clinical Significance of Hematuria." The other out-of-town guest speaker will be Dr. Louis Leiter of New York, who will speak on "Uremia" Saturday morning, November 19, and who will take part in the panel discussion closing the course.

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6, Ohio.



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NEW FIFTY YEAR CLUB MEMBERS

Thirty-four additional physicians became members of the "Fifty Year Club" this year. They were presented with pins and certificates, and were honored in special services at the annual banquet at the state convention. The total membership of the "Fifty Year Club" now is 277. Those honored this year were:

Howard V. Blosser, Fort Wayne; Francis T. O'Leary, Logansport; Karl T. Brown, Muncie; Herbert K. Lemon, Goshen; Glenn Henley, and Joseph P. Seale, Fairmount; Frank A. Van Sandt, Bloomfield; George G. Wimmer, Mt. Etna; Guy W. Hamilton, Madison; Joseph F. Michaels, Edinburg; Louis L. Gilmore, Vincennes; Leroy A. Wilson, Michigan City; Horace E. Crockett, William G. Culloden, Alfred S. Jaeger, Harry K. Langdon, Daniel J. McCarthy, Cyrus W. Rutherford, Urbana Spink, and Ernest deWolfe Wales, Indianapolis; James B. Griffith, Crawfordsville; Edward M. Sweet, Martinsville; John F. Take, French Lick; John E. Taylor, Leopold; Nils Lindquist, South Bend; Guy P. Levering, Lafayette; William R. Davidson, Charles F. Diefendorf, Charles L. Seitz, and Henry G. Weiss, Evansville; Herman L. Bernheimer, Terre Haute; Franklin T. Dubois, Liberty; Charles E. McKee, Dublin; Horace N. McKee, Elkhart.

MEDICAL SCHOOL SCHOLARSHIPS

The Indiana State Medical Association has announced that medical school scholarships have been awarded to Kermit Q. Hibner of Indianapolis and Fred Harless of LaGrange.

Mr. Hibner, who took his premedic work at Butler University, will enter his freshman year at Indiana University School of Medicine in September. The scholarship is worth \$500 a year. Mr. Hibner lives at 342 South Arlington Avenue with his wife. He is a veteran.

Mr. Harless also is married and a veteran. He will start his sophomore year in the Indiana University School of Medicine this fall. His scholarship is for \$200 annually and is financed by a physician's widow. Mr. Harless is the son of Mr. and Mrs. Walter E. Harless of LaGrange.

In announcing the awards, Dr. C. J. Clark of Indianapolis, chairman of the association's scholarship committee, pointed out that Mr. Hibner and Mr. Harless have agreed to practice medicine in Indiana communities needing medical services, upon completion of their internships. Five other students at the Indiana Medical School now hold medical association scholarships.

The purpose of the scholarships is twofold: to assist worthy young men to procure medical educations and to supply small Hoosier towns with physicians.

MEDICAL ADVISORY COMMITTEE

The appointment of the Armed Forces Medical Advisory Committee to act in an advisory capacity to the Secretary of Defense in the fields of medicine and the allied professions was recently announced. The Secretary has asked the committee to submit recommendations on general policies and programs for the National Military Establishment as a whole; on the development of medical services capable of supporting the needs of the armed services efficiently; the elimination of unnecessary duplications in the medical departments of the armed forces, and the development of the maximum continuing cooperation between the members of the civilian and allied professions in the armed services. In addition to advising the Secretary of Defense, the Committee was directed to give advice on medical problems, on request, to the Secretaries of the Army, Navy and Air Force, the Chairmen of the Munitions Board and the Research and Development Board or the head of any other board or agency in the National Military Establishment.

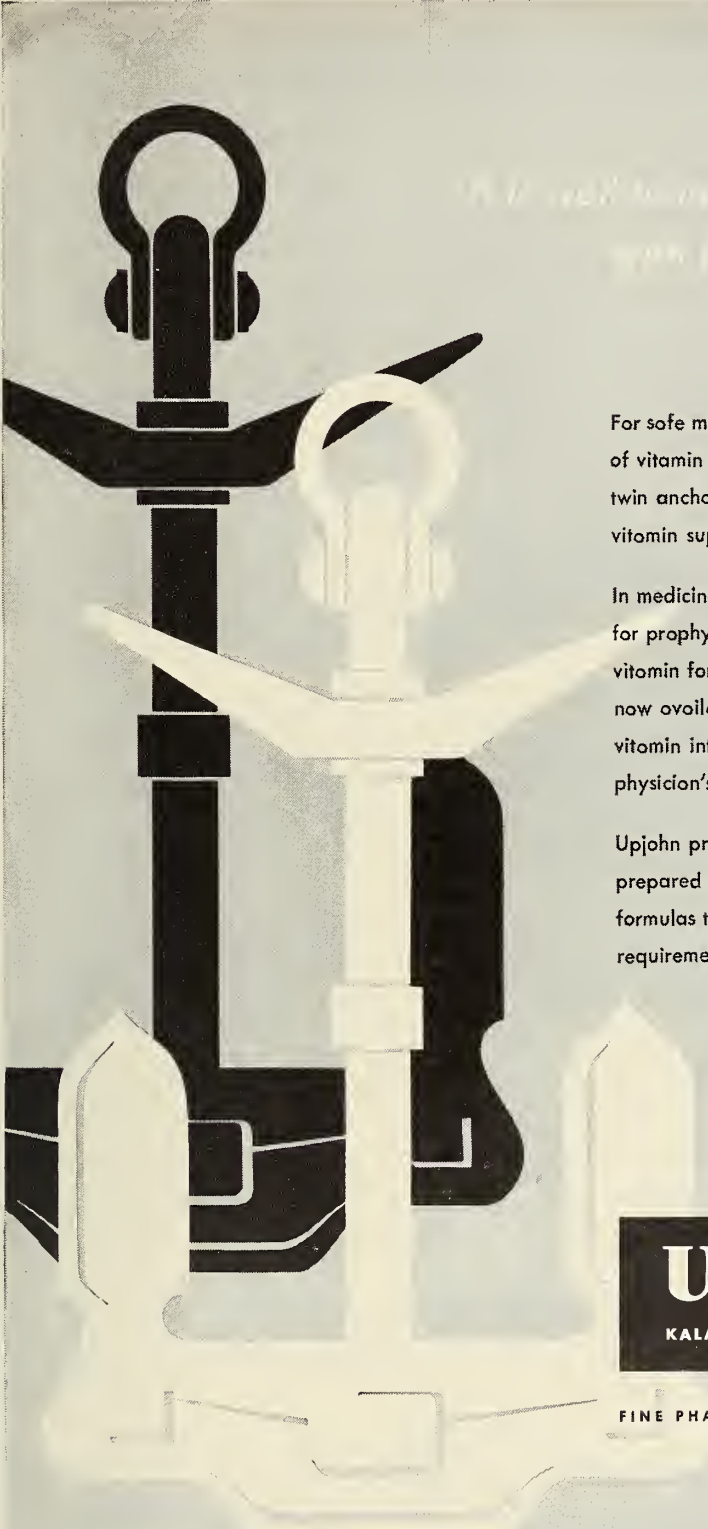
The new committee is expected to examine questions of basic policy affecting the Medical Departments of the armed forces and thus succeed, rather than supersede, the existing Ad Hoc Committee on Medical and Hospital Services (Hawley Board) and to study and make recommendations for improving the services provided by existing medical organizations in the National Military Establishment. In addition to the civilian members of the Board, the Committee members are also: Major Gen. Raymond W. Bliss, Surgeon General of the Army; Rear Admiral Clifford A. Swanson, Surgeon General of the Navy, and Major Gen. Malcolm C. Grow, the Air Surgeon.

The civilian members of the Board are:

Dr. Paul Titus, Pittsburgh; Dr. Raymond B. Allen, Seattle; Mr. Charles P. Cooper, New York; Dr. Richard L. Meiling, Columbus, Ohio; Dr. Edward D. Churchill, Boston; Mr. J. Joseph Whelan, Executive Secretary of the Committee; Dr. Michael DeBakey, Houston, Texas; Daniel F. Lynch, D.D.S., Washington, D. C.; Dr. Maurice C. Pincoffs, Baltimore; Dr. Howard A. Rusk, New York; Dr. Francis J. Braceland, Rochester, Minn.; Walter H. Scherer, D.D.S., Houston, Texas, and Dr. Paul R. Hawley, Chicago.

UNIVERSITY APPOINTMENT

Dr. Herbert S. Gaskill, associate in psychiatry of medicine at the University of Pennsylvania School of Medicine, Philadelphia, has been appointed professor of psychiatry at the Indiana University School of Medicine. Doctor Gaskill, who is a graduate of the University of Pennsylvania in 1937, serves as a consultant in neuropsychiatry to the Surgeon General's office.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

August 28, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; A. P. Hauss, M. D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney, and J. A. Waggener.

Membership Report

Number of members August 27, 1949.....	3,701*
Number of members August 27, 1948.....	3,622
Gain over last year.....	79
Number of members December 31, 1948.....	3,689

*Includes 36 in military service (gratis)
188 honorary members

Treasurer's Office

The treasurer of Mutual Medical Insurance, Inc., who is also treasurer of the state medical association, gave a report on the financial condition of the company.

Legislative Matters

National

Copy for Mutual Medical Insurance display cards was approved on motion of Drs. Hauss and Ellison.

Statements of receipts and expenditures for July for the association and *THE JOURNAL* were approved.

1949 Annual Session, Indianapolis, September 26-29, 1949

Scientific and historical exhibits. It was taken by consent that these exhibits shall be open to the public on Tuesday, Wednesday and Thursday during the regular hours of the convention, and it was suggested that an effort be made to get the exhibitors to keep their exhibits open on Tuesday and Wednesday evenings.

Permanent convention badges. On motion of Drs. Portteus and Ellison, the committee voted to adopt a permanent type convention badge, the executive and field secretaries to select the badge to be used.

Bronze plaque for past presidents. Dr. Weyerbacher, a member of the committee appointed to select the design and text for such a plaque, reported that the committee had made its selection. Each plaque will carry the recipient's name, which will entail a slight additional charge over that previously reported.

Upon the motion of Drs. Portteus and Ellison, the committee voted to invite the Superintendent of Public Instruction, the superintendent of the Indianapolis City Schools, and Senators Capehart and Jenner to attend the annual dinner Thursday evening.

Dr. Henry G. Weiss of Evansville was selected to give the response in behalf of the Fifty Year Club, on motion of Drs. Ellison and Portteus.

It was taken by consent that two copies of *ONE HUNDRED YEARS OF INDIANA MEDICINE* shall be presented to the major contributors.

Personal liability insurance. Upon motion of Drs. Ellison and Portteus, the committee voted to have a rider attached to the policy that has been drawn up to cover the Indiana Roof for the night of the banquet.

Speakers' table arrangements. The committee voted to leave the seating arrangements for the speakers' table

and guests to a committee composed of Dr. Hauss and the executive and field secretaries.

Payment of hotel expenses for wives of outstate speakers. On motion of Drs. Portteus and Ellison, it was agreed to pay the hotel bill for the wives of the outstate guest speakers but not to pay transportation costs for the wives.

Employment of policemen. Upon motion of Drs. Ellison and Portteus it was voted to employ uniformed policemen for doormen, to be placed at the entrance to the technical and television exhibits, the number and hours of employment to be left up to the judgment of the executive secretary.

Organization Matters

The address of Dr. Black to the House of Delegates was approved by consent.

Life insurance examination fees. On motion of Drs. Portteus and Hauss it was voted that a survey be made on this question by sending out questionnaires.

The committee approved the acceptance by the executive secretary of the invitation to attend the annual dinner of the Kentucky State Medical Association, October 7, in Owensboro, Kentucky.

The committee approved acceptance of the invitation addressed to Dr. Hauss to attend the annual meeting of the State Medical Society of Wisconsin in Milwaukee, October 3, 4 and 5. Dr. Hauss or Dr. Black is to represent the Indiana State Medical Association.

Scholarship fund. Consideration of a magazine subscription plan to raise money for scholarships was postponed until the next meeting of the committee.

THE JOURNAL

Report on advertising:

Increases to August 28, 1949.....	\$101.50
No decreases	

Total increase for month.....	\$101.50
Total increase for year.....	\$3,587.85

There being no further business, the Executive Committee adjourned to meet again at 6:30 p.m., Sunday, September 25, at the Columbia Club.

COMMITTEE ON PUBLICITY

August 5, 1949

Present: James O. Ritchey, M.D., chairman; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and J. A. Waggener, field secretary.

A news release about the 1949 state meeting, containing an announcement by the president of the dates and personnel of the Committee on Centennial Arrangements, was approved.

The executive secretary announced that *The Indianapolis Star* will issue a special section Monday, September 26, in connection with the centennial convention, and that the committee would be asked to pass upon the reading material and the advertisers.

The following "Hints on Health" columns were approved:

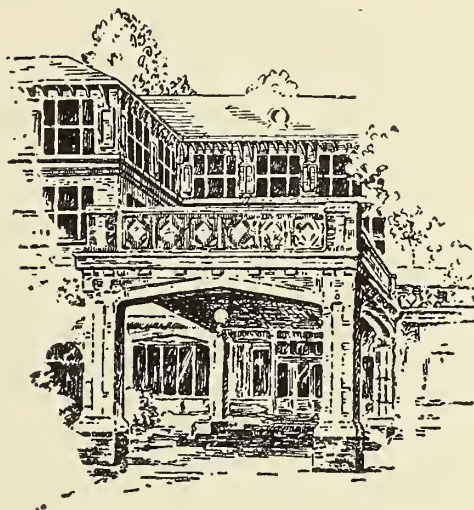
Week of September 5, 1949—"Heartburn."

Week of September 12, 1949—"Scurvy."

Week of September 19, 1949—"Mechanical Backache."

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MEDICAL STAFF

M. C. PITKIN, M.D., *Director*

J. H. GRIMES, M.D., *Assistant Director*

L. M. HUGHES, M.D., *Assistant Director*

Deaths

Elmer H. Brubaker, M.D., of Indianapolis, died on August 22 after a long illness. He was eighty years of age. A graduate of the Physio-Medical College of Indianapolis in 1896, Doctor Brubaker had practiced in Indianapolis since 1912. He was an honorary member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

* * *

Quincy Robert Hauss, M.D., of Sellersburg, died on August 10, after a brief illness, at the age of eighty-four. He graduated from the Eclectic Medical College of Cincinnati in 1887, and had been in practice for more than sixty years. He had retired in March 1948.

* * *

Christian W. Rieff, M.D., retired physician of Idaville, died on August 23, in Logansport, after an illness of four years. He was a graduate of the Eclectic Medical College of Cincinnati, in 1901, and had practiced in Idaville from 1903 until he retired, in 1946. He was seventy-three years of age.

William Judson Martin, M.D., of Kokomo, died suddenly on August 24, at the age of seventy-nine. He had practiced in Kokomo for more than forty-three years. Doctor Martin graduated from the St. Louis College of Physicians and Surgeons in 1903, and began the practice of medicine in Red Oak, where he practiced for three years before going to Kokomo in 1906. He was a member of the Howard County Medical Society, the Indiana State Medical Association, and the American Medical Association.

* * *

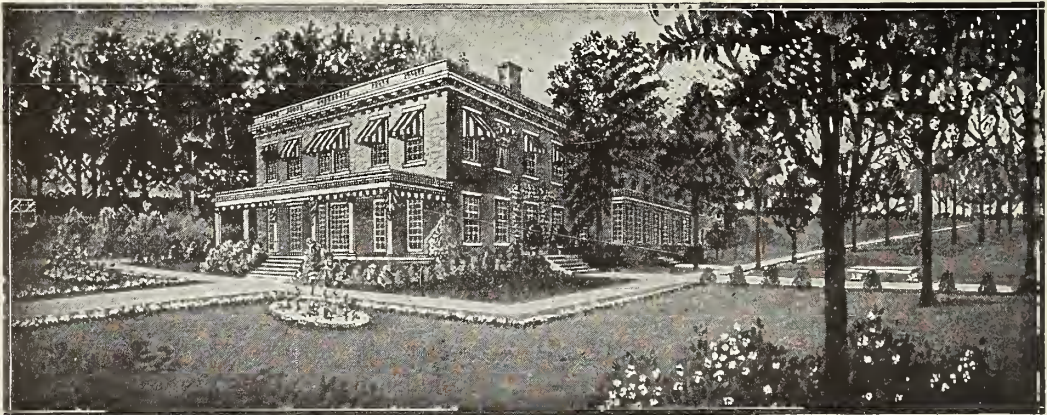
William Carroll Winstandley, M.D., of New Albany, died suddenly on August 30, at the age of seventy-seven. He graduated from the University of Louisville School of Medicine in 1896, and had practiced continuously in New Albany since that time, with the exception of the time he served in the Army Medical Corps in World War I. He was an honorary member of the Floyd County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 42

NOVEMBER, 1949

NUMBER 11

PRESIDENT'S ADDRESS*

AUGUSTUS P. HAUSS, M.D.

NEW ALBANY

FELLOW members of the Indiana State Medical Association, beloved members of the Woman's Auxiliary, and distinguished guests:

We are assembled here on a great and historic occasion, the centennial anniversary of our state medical association.

We are here to pay an honorable and deserving tribute to the pioneer physicians whose rugged individualism and courageous initiative founded one hundred years of organized medicine in Indiana.

There were few railroads in Hoosierdom in 1849. The trains were slow and far between. Telephones were unheard of and most mail was carried by messenger, stagecoach, or small river boats. There were no superhighways or paved roads and, during the winter and wet spring months, travel was impossible, except on foot or horseback. Two or three days were often required for a physician to make a single call—a distance that can now be traveled in half an hour. They did not "call a doctor" in those days. They went for him. Somehow, the doctor always got there some way.

There were few apothecary shops and no pharmaceutical distributing services. Most of the pioneer physicians were also apt students of botany and geology. They gathered their own medicinal plants, roots, herbs, and minerals from the fields and forests and rock-bound hills and made their own concoctions, tinctures, infusions, pills, powders and poultices. It is interesting to note that much of the early history of Indiana Medicine is built

around one Dr. Asahel Clapp, of New Albany—a charter member of this association and its second president—and who was internationally known as a botanist and geologist.

He was chairman of the A. M. A. Committee on Indigenous Medical Botany and Materia Medica in 1850-51. His book on Medicinal Plants of the United States, published in 1852, made him internationally renowned.

Physicians and scientists of national and international note made a beaten path, through the Indiana woods, to his door—including Dr. Oliver Wendell Holmes, James D. Dana, and Dr. Daniel Drake of Cincinnati.

James Hall of New York made repeated trips, and Sir Charles Lyell, then the most distinguished geologist of England, visited him on April 4, 1846. Dr. John Coulter, president of Indiana University in the 1840's, was a frequent visitor and each time carried away many rare botanical and geological specimens that are now treasured by our great University of Indiana.

Harvard University also received from Dr. Clapp an unusual collection of geological specimens that have been kept intact as the Clapp Collection.

Dr. Clapp came to Indiana in 1817 and three years later, at the age of twenty-eight, was elected the first president of the Medical Society of the State of Indiana at Corydon in 1820, twenty-nine years before the organization of our present association.

History records that in 1837 Asahel Clapp was the most famous man in Indiana. In 1849 we find him at the medical convention in Indianapolis

* Presented before the General Meeting of the Indiana State Medical Association, at Indianapolis, on September 27, 1949.

among "the lode stars around which the lesser lights of medicine revolved."

Dare anyone dispute that Asahel Clapp of New Albany blazed the trail for organized scientific medicine in Indiana?

It might be said that the migration of medicine into Indiana followed the Ohio River and the Great Lakes. LaPorte was disputing Chicago's claim as the metropolis of the West at the beginning of the 18th century. Madison, New Albany and Evansville were considered hustling river towns and each had a doctor's row, atop the river bank.

The first District Medical Society was organized in Vincennes, prior to 1818 when Indiana was a part of the Northwestern Territory. It would be well for the delegates here today to go back and remind their county societies that as early as 1827 the Vincennes Society allowed each delegate to the state convention travel expenses of ten dollars.

That was in the days when a hind-quarter of beef could be purchased at 2½ cents a pound, and Abraham Lincoln's tavern, in nearby Illinois, was providing lodging for one person at 12½ cents, for one horse 25 cents, and to assure you of a good night's rest, a half pint of whiskey for 12½ cents; a total cost of fifty cents for man and beast.

Four medical schools were chartered in Indiana, prior to the organization of our present state medical association: The Medical College of Evansville in 1849; LaPorte University School of Medicine in 1841, (William W. Mayo, the elder, enrolled there in 1849, and Wm. H. Wishard of Indianapolis was probably its most distinguished graduate); Vincennes University Medical Department in 1837; and first among the charters granted was the Christian College of New Albany in 1833. History states that this alpha of our medical schools was never intended to teach anything, but issued for a short time fraudulent diplomas under the names of The Christian College, the University of New Albany, and the University of Indiana.

It is quite possible that the University of New Albany in 1833 inspired some of the tactics of the cultists of 1949.

It is also obvious that the Floyd County Medical Society was quick to put its house in order, for the diploma-mill lasted less than a year.

Corydon became the capital in 1816, when Indiana became a state. It was there that the first state medical society of Indiana was organized in 1820 and continued to function for at least ten years.

Then history records, and I quote: "About 1830 Indiana gave up all pretense of regulating medical practice as did most of the other states of the Union. Democratic Americans, as little appreciating the need for trained men in medicine as in government, insisted upon judging a doctor's qualifications for themselves, nor could medical men

agree as to who among them should have a license."

Medical sects and cults were many and acrimonious. The botanic physician battled the calomel doctor. The all-which ridiculed the homeopath, and all damned the water cure of the hydropathists, the steam bath of the Thomsonians, and the mixed therapy of the eclectics.

Unorganized medical care ran rampant, unleashed and unlicensed in Indiana from 1830 to 1849.

Science and the true disciples of Aesculapius took a back seat to witness the parade of a deluded democracy, following the siren call of the medical charlatans and the itinerant quacks, who moved swiftly from place to place leaving a trail of useless nostrums, worthless counsel, disappointed hopes, and DEATH!

Need I remind you that history has often repeated itself and that which happened to Hoosier medicine in the 1830's could happen again in Indiana and throughout democratic America as well?

Following this era of rape and debauchery of Indiana medicine, a second legitimate child was born in 1849, destined to live and lead our noble profession out of the wilderness.

Dr. Livingston Dunlap of Indianapolis was the honored and legitimate father of this distinguished son, conceived in the womb of the Indianapolis Medical Society.

Our great Indiana State Medical Association was born June 6, 1849, in Wesley Chapel, Indianapolis (not on the sidewalks of New Albany).

Eighty-four physicians were in attendance at that historic birth, each skilled in the medical art of midwifery of the day.

They came from many parts of Indiana: There were two who traveled all the way from Jeffersonville and one from far-off Vincennes, and, pardon me if I slightly emphasize that there were nine from New Albany.

Dr. William T. S. Cornett of Versailles was elected the first president of the state society, Dr. Clapp the first vice-president, and Dr. John S. Bobbs, of Indianapolis, founder of cholecystotomy, the first secretary.

This great state medical association has lived under American free enterprise for one hundred consecutive years; a record of continuous service that has been exceeded only by three other sons of American medicine—Ohio, Pennsylvania and Tennessee.

Paraphrasing a statement I made one year ago, which I regret offended some, but alerted more, may I now say "Scientific American medicine must not die on the desk of the President of the United States."

James K. Polk was President of the United States in 1849. He asked Congress for thirty-three million dollars to pay interest on the public

debt. Your Uncle Sam was in the red a hundred years ago. President Polk thought twenty-five million dollars would be ample to cover the "ordinary" expenditures of the government for the year. Compare this with the millions now appropriated in Indiana for our state universities, hospitals, benevolent institutions, and public health.

James Whitcomb was Governor of Indiana in 1849, and on October 7th of that year another famous son was born and named after him, one who became Indiana's most beloved son of all time—James Whitcomb Riley—the poet laureate of Indiana and devoted champion of the Hoosier doctors.

We could not celebrate our own Centennial today without idealizing the one hundredth birthday of our friend who said:

"We may idealize the chief of men—
Idealize the humblest citizen,—
Idealize the ruler in his chair—
The poor man, or the poorer millionaire,—
Idealize the soldier—sailor—or
The simplest man of peace—at war with war;—
The hero of the sword or life and drum . . .
Why not idealize the Doctor some?"

Gold had been discovered in California in 1849 and many citizens of Indiana closed up their stores and quit their jobs to follow the dusty trail of the covered wagons, the Gold Rush of '49. There is no doubt that many of the medical quacks and charlatans left Indiana at that time *to seek further for gold*. The physicians of Indiana, who had dedicated their lives to the advancement of science and humanitarian medical care, remained to organize and make our association great.

Asiatic cholera struck New Orleans late in 1848 and marched up the Mississippi, Ohio and the Wabash, into Indiana. It reached LaFayette July 3, 1849, one month after our organization was formed. It spread rapidly throughout the state. In LaFayette three hundred fatalities were reported, a rate of fifteen deaths per day, while the fury lasted.

The etiology, prophylaxis and treatment of Asiatic cholera was unknown in 1849. They only knew that again this dreaded plague had lifted its ugly head in Persia, spread havoc and destruction westward across all Europe, then into the United States, and in Indiana sickness, death and terror ruled.

Out of this baptism of fire came the Indiana State Medical Association, to live and serve the people of Indiana for one hundred years.

Today we have come back home to honor the memory of our father, Dr. Livingston Dunlap, who received from above his last call in 1862; and to be with our mother, The Indianapolis Medical Society, who still lives, revitalized by the scientific medicine of her sons.

I need not relate or eulogize the century of progress in scientific medicine in Indiana, or pay

tribute to the men who made it great, for today in this great hall we have pageantry of historic, scientific and technical exhibits unequaled by any state medical association, and an all-Hoosier scientific program representing many of the great medical centers of America.

I need only add in the words of Kipling:

"The men bulk big on the old trail, our own trail,

They are God's own guides on the long trail, the trail that is always new."

All that I have said is history you probably know, but I have presented these facts to remind you that history has repeated itself over and over and over again.

I can see in the breakdown of regulations in medical practice in 1830 and the reign of the charlatans and quacks a similarity to the onward march of the cults today. Each legislative year they come a little closer to their goal.

In or about 1838 democratic Americans insisted upon judging a doctor's qualifications for themselves. Is this any different from the mandate of the people in 1948 who followed a political panacea and voted for socialized medicine?

I see in the squabbles between the botanic physicians and the calomel doctors, the allopath and the homeopath, something that is akin to the friction in some of our county medical societies and hospital staffs.

Thanks to scientific medicine Asiatic cholera is no longer a major threat, but out of the East I see a more destructive plague that has swept westward over all of Europe into the United States and is lurking and hiding its ugly face here in Indiana in 1949.

Sovietism is its proper name, but it travels under many *nom de plumes*. It has destroyed all of the great medical centers of Europe, the Continental democracies and taken away the freedom of many of the peace-loving nations.

Less than a half century ago London, Heidelberg, Vienna, and other great European medical centers were considered the fountainheads of medical knowledge.

These great medical centers of yesterday are now struggling for their very existence under a totalitarian state or socialistic government, and the world looks to America as the leader of scientific medicine.

Under American free enterprise there has been more scientific advancement in medical care during the past one hundred years than in the previous two thousand years of medical history.

We free men must not forget that for every right there is an obligation.

We are justly proud of the part that Indiana has played in the advancement of American medical care.

The Indiana State Medical Association is alert to its responsibilities in community health and is aware of its obligation to provide adequate care for the people of Indiana.

It enters the new century of Indiana Medicine with a sincere and humanitarian program attuned to the progress and needs of the state.

It has endorsed the establishment of full-time health officers and adequate local public health units, locally controlled; and offers cooperation and scientific medical guidance to community health councils and all the meritorious volunteer agencies of health.

It is providing information and programs on health education to promote better health, less sickness, and less need for medical care.

It is encouraging the development of diagnostic facilities, health centers, and hospitals, locally promoted and administered, in areas in which the need exists.

It favors more doctors and nurses, more adequately distributed to serve the citizens of our state, and has established scholarships for medical and nursing students who will locate and practice their professions in the rural areas and in the communities where the need is greatest.

It has sponsored and established volunteer pre-paid hospital and medical care insurance to meet the major costs of illness. These nonprofit agencies are now serving several hundred thousand people in Indiana, and are growing at a phenomenal rate.

"Around-the-clock" medical care is now being provided by most of the county medical societies in Indiana, and doctors are available at night, on Sundays, holidays, and on Wednesday afternoons, too. In most of Indiana there is freedom from fear of not being able to get a doctor in an emergency.

Next month our state medical association will sponsor a state-wide "Diabetes Detection" Survey, the most extensive ever attempted in the United States.

These are just a few of the many things the family physician, the county medical society, and the Indiana State Medical Association are doing to provide better health and medical care for the people of Indiana and to continue the advance of scientific medicine in the American way.

Courageous initiative and free enterprise made America great!

And made America the healthiest nation in all the world!

THE VALGUS FACTOR IN FRACTURE OF THE ANKLE

E. B. MUMFORD, M.D.

INDIANAPOLIS

THE following discussion of the valgus position of the foot as an important factor in the impairment resulting from a fracture of the ankle, and the proposed operative procedure to correct this valgus deformity, are concerned only with those cases in which the dislocation in the tibiotalar joint has been reduced, in which the ankle joint is free of any traumatic arthritis and in which all motions of the foot (flexion and extension, internal and external rotation) are either normal or only slightly restricted by soft tissue scar contractures.

Impairment due to pain and instability in the foot and ankle is not an uncommon condition in the end result of fractures of the ankle. The purpose of this presentation is to show that these symptoms of pain and instability may be due entirely to the lesion of the internal lateral (deltoid) ligament of the ankle and that the relief of the symptoms may be attained by a simple plication of the deltoid ligament to correct the faulty valgus weight-bearing position of the foot.

In order to clarify the phraseology used in the discussion it is necessary to have a clear understanding of the terms designating fractures of the ankle, valgus position of the foot and the effect of the forces causing the fracture.

FRACTURES OF THE ANKLE

Fractures of the ankle designate those fractures of the tibia and fibula which result from a forcible inversion or eversion of the foot beyond the normal physiological range of these motions. The forward dislocation of the tibia upon the talus, which may be associated with a fracture of the posterior lip of the tibia, will not be considered, as this phase of any fracture of the ankle must be corrected in so far as the dislocation is concerned. Nor will the limitation of flexion and extension in the ankle due to the scar tissues resulting from the laceration of the capsule and ligaments be affected or changed by the operation to be suggested later.

The treatment of the fresh fracture of the ankle

joint is orthodox, in that an attempt should be made to restore to normal any derangement in the joint or any malposition in the fracture lines.

However, it is often impossible to restore the normal width of the mortise of the ankle joint and interposition of soft tissue or some other factor may prevent complete bony healing in the fracture line in the tip of either malleolus. It is my opinion that neither of these conditions in themselves are of any considerable importance in the resulting impairment. This is contrary to previous teaching, especially that relative to the widening of the mortise. Too much importance has been given to the x-ray findings and not enough to the faulty weight-bearing due to the change in the internal lateral ligament. The changes in the capsule and other soft tissue, due to the laceration and to the infiltration of the tissues with blood and later with plastic exudate, are changes not shown in the x-ray film.

If one is to accept the premise that the valgus weight-bearing deformity is a dominant factor in the late impairment in fractures of the ankle the prevention of this deformity becomes a most essential part of the treatment. After reduction of any dislocation and of the fractures the foot should be immobilized in a varus position. This varus position should be to full degree in those fractures caused by eversion of the foot and to less degree when the force was one of inversion. This varus position should be maintained for several months after the splintage has been removed by elevating the inner border of the sole of the shoe one-quarter of an inch and using an anatomic heel elevated one-eighth inch on the inner side.

LESIONS CAUSED BY INVERSION AND EVERSION

Fractures of the ankle fall into four types, those with a fracture of the internal malleolus, those with a fracture of the lower portion of the fibula, those with a fracture of the posterior rim of the tibia and associated with a forward dislocation of the tibia, or a combination of any or all of these types.

A study of the sequence of the changes which occur when the foot is everted beyond the normal range may be visualized as follows: As the foot is everted, a force is exerted against the external malleolus. As this force continues, the tibiofibular ligament gives away, allowing the fibula to be sprung outward on a hinge in the interosseous ligament or even in the proximal tibiofibular ligament at the knee joint. If the force continues, the fibula will fracture at some point above the external malleolus, usually in the narrow lower fourth. At the same time the changes are occurring in the fibula a stress is being exerted upon the internal lateral ligament of the ankle. This ligament either becomes loosened at its bony attachment (sprain) or the tip of the internal malleolus fractures and this portion of the malleolus is pulled beneath the

tibia, thus relaxing the internal ligament. *A valgus deformity of the foot is thus created.*

When the foot is inverted, the force is exerted against the internal malleolus. As the force continues the malleolus is fractured at its base but without any, or but little, stress upon the internal lateral ligament. At the same time the external ligament is under a pulling force and becomes detached from the external malleolus or the external malleolus fractures at a low level and is carried inward beneath the ankle joint. The strain upon the tibiofibular ligament is not as great as it is when the foot is everted and, therefore, there may be little, if any, widening of the mortise of the joint. The foot is thus at first in a position of varus but inasmuch as the internal lateral ligament, because of the fracture line in the internal malleolus, has become potentially loosened and the external malleolus fractured, the foot, upon weight-bearing, will be thrown into a valgus position. Thus one finds ultimately a valgus weight-bearing foot in either the inversion or in the eversion type of fracture.

THE VALGUS DEFORMITY

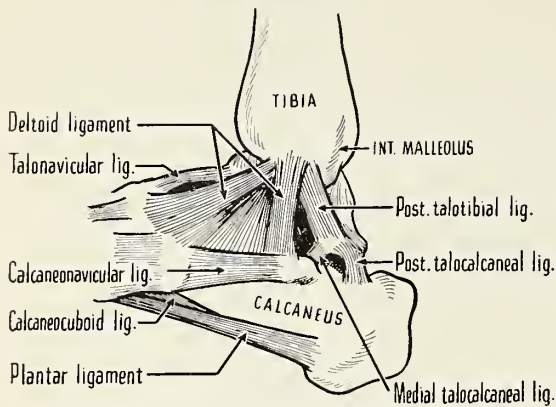
A valgus position of the foot results either from changes in the tissues above the line of the tibiotalar joint or those below this level. These changes in the tissues may be either congenital or acquired or due to disease or trauma. In the present discussion a valgus position of the foot resulting from disease or trauma to the tissues above the ankle (severed tendons, nerve lesions, scar contractures, fractures of the shaft of the tibia) or as a result of congenital malformation will not be considered as a factor. Only a valgus deformity resulting from a fracture of the ankle will be discussed.

A fracture of the shaft of the tibia involving the entire width of the bone may produce through angulation in the fracture line a valgus weight-bearing position of the foot, but such valgus deformity is not due to a lesion of the internal lateral ligament of the ankle and the correction of the valgus foot must be attained through restoring the normal alignment in the tibia. However, as a valgus position of the foot following fracture of the ankle results only from a severe lesion below or at the level of the tibiotalar joint, the valgus deformity is possible only when there is a lesion involving the internal lateral ligament of the ankle joint. In the everted foot the deltoid ligament is either torn loose from the tip of the internal malleolus or a small detached part of the malleolus remains attached to the ligament. In the inverted foot the ligament is not strained but loses its continuity with or its attachment to the shaft of the tibia through the fracture line in the base of the internal malleolus.

ANATOMY OF ANKLE

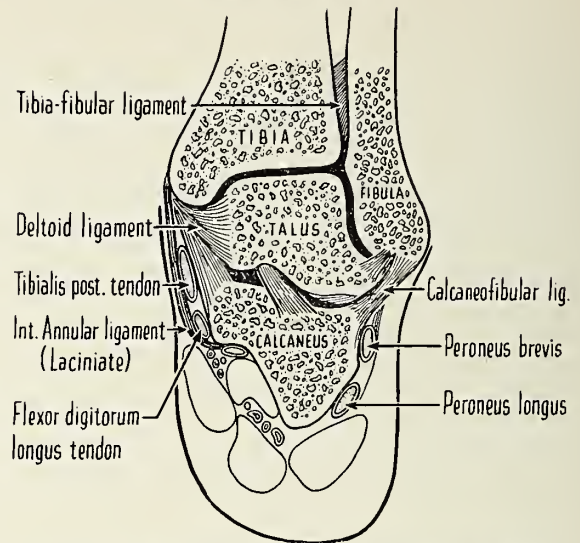
As dissection is carried to the deltoid ligament, the anatomical findings are as follows (illustrations

Illustration No. 1



Ligaments of ankle from medial side (Gray's anatomy).

Illustration No. 2



Cross section through ankle. Note position of internal ANNULAR ligament and the internal LATERAL (deltoid) ligament (Gray's anatomy).

1 and 2): In the subcutaneous tissue the sensory branches of the internal saphenous nerve should be identified and preserved. The next layer encountered is a glistening, firm, rather thin sheet. This is the lacinate or *internal annular ligament*, which ligament has its upper attachment to the internal malleolus and its lower attachment to the calcaneus and the plantar fascia. It covers the flexor tendons and the posterior tibial vessels and nerves. Beneath the tibialis posterior and the flexor pollicis longus tendons lies the deltoid or *internal lateral ligament* of the foot. This ligament is fan-shaped, extending from the internal malleolus in a broad sheath to the navicular bone and in a heavy band to the calcaneus. Lying just posterior to this deltoid ligament is another strong narrow ligament (the posterior talotibial ligament). The capsule of the joint which lies beneath the deltoid ligament is not cut.

OPERATION

As stated previously, if one accepts the premise that the valgus weight-bearing deformity resulting from a fracture of the ankle is the cause of the pain and the disability producing the impairment in this type of injury, and furthermore, if one accepts the premise that such valgus deformity is caused entirely by a stretching or a relaxation of the internal (deltoid) lateral ligament of the ankle, one must accept as logical that the correction of this ligament lesion is the proper plan of attacking the problem.

After the usual preparation of the skin and the application of a tourniquet, a slightly curved transverse incision is made through the skin about one inch below the tip of the internal malleolus of the tibia. Carefully avoid cutting any of the sensory nerve branches. The skin flaps and the

subcutaneous tissue are retracted exposing a rather wide, thin, glistening, but strong, fascial sheath, the *internal annular ligament*. This is divided transversely and the tendons of the tibialis posterior and flexor digitorum longus muscle are retracted, exposing the thick, strong, but rather short *deltoid* or *internal lateral ligament*. The internal lateral ligament is cut transversely through the center of the ligament to form two flaps. It is not necessary to cut the capsule of the joint. The two flaps of the deltoid ligament are dissected freely to their bony attachment. The foot is brought into marked inversion and the two ligamentous flaps are overlapped (plicated) and sutured with silk. Schumm has sutured these flaps with staples. The tendons are allowed to fall into their normal position and the two flaps of the internal annular ligament are also plicated and sutured with No. 1 chromic. The subcutaneous tissue is sutured with catgut and the skin with fine silk. The foot by itself should then retain a neutral or slightly inverted position. The foot is immobilized in a plaster of Paris splint extending from the toes to the knee and in an inverted or varus position. The splint can incorporate a walking heel and the patient be ambulatory at the end of one week. The splint is removed at the end of eight weeks and the varus position in weight-bearing maintained by elevating the inner border of the sole one-fourth inch and the inner border of the heel one-eighth inch. This shoe correction is worn for six months.

The end result obtained in the limited number of cases has been most satisfactory to the patient, in that instability has been so improved that walking is possible without the use of cane or crutch

Illustration No. 3



Note the widening of the ankle mortise and the slight varus position of the foot. This represents the postoperative x-ray.

and the pain has been eliminated. One important feature of the operation is that if improvement is not obtained, the more radical approach to the problem through an arthrodesis of the tibiotalar joint can be advised.

CASE I

V. H. (illustration No. 3)—Male, age 23. While playing football September 26, 1934, sustained a fracture of the left ankle. Reduction was followed by plaster of Paris fixation for six weeks. He did not participate in athletics the rest of 1934. Although he did not have much pain and did not have to use a cane or crutch he was unable to run or turn due to instability in the ankle joint.

I first saw this patient in February, 1935, at which time he had some pain and the instability of the ankle prevented him from entering athletics. The ankle was somewhat enlarged and upon weight-bearing the foot assumed a valgus position. There was no loss of motion in the ankle joint nor in the midfoot. Full eversion was painful.

After the fibula was osteotomized and a futile attempt made to restore the width of the ankle joint, a plication of the deltoid ligament of the left ankle was done. This shortening of the ligament gave a moderate varus position of the foot and fixation in a full varus position was maintained by a plaster of Paris splint for eight weeks and then by an elevation of the inner border of the shoe. Light exercise was permitted during the summer months and in September, 1935, he took up full football practice. He played college football in 1935 and 1936, intercollegiate basketball in

Illustration No. 4



Note the extreme widening of the mortise of the ankle joint. Postoperative x-ray.

1935, 1936 and 1937, football in the all-star game in Chicago in 1937, and professional football with the Detroit Lions in 1937 and 1938. During his college years, he received All-American mention in football and in basketball. Since 1938 he has played softball every summer, as well as golf, basketball and baseball. He had four years of military service in World War II.

Since the fall of 1935, he has not had any pain or instability in the ankle or foot and is unconscious of any limp in his walk.

Illustration 3 is the x-ray made in 1944 while in the Army, and through the courtesy of Dr. Roger Anderson. The original x-rays were lost but the recent x-ray shows the same changes in the joint as seen in the x-rays made in 1935. Note the widening of the mortise of the ankle joint and the slight varus position of the foot after operation. This is the condition which *now exists and was present during his athletic career.*

CASE II

E. W. (illustration No. 4)—White female, age 60, doing work as a farmer's wife. In October, 1942, she fell, causing a fracture of the ankle which was of the eversion type, with an oblique fracture of the fibula just above the malleolus. There was no fracture of the internal malleolus. A forward dislocation of the tibia upon the foot was associated with a fracture of the posterior tibia with only slight displacement. The widening of the mortise of the ankle joint was $\frac{5}{8}$ inch. An attempt was made to reduce the fracture and the foot was immobilized for several weeks.

The patient was first seen by me in November, 1943, at which time she stated that since the removal of the splint she had had an almost total disability, in that she had to use crutches on account of pain and swelling and instability in the ankle. At times the pain was so severe that

it "made her sick at her stomach." She was able to do but little of her house and farm work. X-rays made at this time (1943) (illustration 4) shows practically the same findings as those made immediately after reduction in 1942. The foot was displaced outward and, upon weight-bearing, assumed a marked valgus position. The ankle was swollen; there was a limitation of all motions.

Conservative treatment and the use of a corrective shoe with the inner border elevated did not give any relief. October, 1945, the fibula was osteotomized and an unsuccessful attempt was made to reduce the widening in the mortise, and the dislocation in the tibiotalar joint was partly reduced. A plication of the internal lateral ligament was then done, bringing the foot into inversion. The full inverted position was maintained for ten weeks, following which a corrective shoe was worn for one year. The pain subsided, but an elastic bandage was worn to control the swelling.

October, 1945, the patient was re-examined. Weight-bearing was without pain but the foot was in too much varus, giving rise to a thick callus along the outer side of the forefoot. There was no instability, and crutches and cane were not used. Her chief complaint was a numbness in the top of the foot giving a heavy feeling which made her cautious in going up and down stairs. She is doing practically all her former work about the farm. The postoperative x-rays (illustration 4) made in 1946 show the same widening of the mortise but with less dislocation in the ankle joint as seen in the 1943 x-rays. The foot is in a varus position. The osteotomy of the fibula is healed.

CASE III

D. H.—A white female, age 75, housewife. September, 1945, she fell down some steps, causing compound fracture of the left ankle. The x-rays made in 1945 showed a fracture of the internal malleolus with the fragment displaced inward beneath the tibia. There is but little widening of the mortise as the internal malleolus followed the outward displacement of the talus (foot). There was also a fracture of the posterior portion of the tibia with some dislocation in the tibiotalar joint. After initial reduction, the foot was immobilized for eight weeks. There was no infection in the compound wound.

The patient was first seen by me in the summer of 1946 and at that time she was complaining of pain and instability in the left ankle and crutches were used. There was some swelling in the ankle and foot. Motions in the ankle joint were restricted and painful, and associated with a definite click. The toes were very stiff.

Conservative treatment did not improve her condition and a simple plication of the internal lateral ligaments of the ankle was done. Fixation of the ankle was maintained for eight weeks and a shoe with elevation of the inner border has been

Illustration No. 5



Note fracture of internal malleolus. Not any widening of mortise of ankle joint.

worn at all times. Osteotomy of the fibula was not done.

Examination was made in April, 1947. The patient stated that she was able to walk about the house without as much pain and without instability, but used a cane out of doors as the numbness on the outer side of the foot gave her a sensation of heaviness and insecurity. Compared with her condition prior to operation, she stated that she was very much better due to less pain.

The postoperative x-rays made in 1947 show the position of the foot as being displaced outward in the tibiotalar joint and the internal malleolus somewhat under the tibia. The dislocation in the tibiotalar joint appears reduced. The foot is in slight valgus.

The ankle is somewhat enlarged. Motion is fairly normal and upon weight-bearing the foot is in a neutral position. The end result in this case is not as good as was obtained in Case I and Case II, which may be due to the scar tissue about the ankle resulting from the compound wound and to some traumatic arthritis in the tibiotalar joint. This case, due to the arthritis, was not a favorable one for operation, but the improvement in the stability made the operation worthwhile.

CASE IV

A. M. (illustration 5)—A white female, 35 years of age, housewife. She fell in May, 1946, causing a fracture of the left ankle. The fibula was fractured through the base of the external malleolus and through the base of the internal malleolus. There is no apparent widening of the mortise of the joint. These findings indicate a fracture of the eversion type. A small fragment seems to have been broken off the posterior part of the tibia but without any dislocation in the ankle joint.

Reduction was maintained by a plaster of Paris splint for six weeks and, since that time, an elevation of the inner border of the shoe has been used.

This case is interesting in that as long as the foot is maintained in a varus position by the shoe correction, she is without pain and able to do her work or to go shopping. However, if she walks without the corrective shoe, the foot becomes painful.

In the film (illustration 5) it is to be noted that, although the main portion of the internal malleolus is in normal position and the fracture at the base reduced, there has also been a fracture of the tip of the malleolus. This would make possible a relaxation of the internal lateral ligament of the joint and a valgus weight-bearing position of the foot and thus a painful flat foot.

CONGENITAL PES VALGUS

The underlying factors of pes planus (flatfoot) are similar to those discussed in reference to the fracture of the ankle. In the flat foot these factors are the relaxed internal ligaments of the foot, especially the deltoid ligament, together with an outward rotation of the calcaneus and a shortening of the tendo calcaneus. Operations have been suggested for the correction of the valgus deformity but all involve some bone changes such as sug-

gested by White and by Hoke. If the plication of the deltoid alone is done for flaccid pes planus, the plication should include the posterior talotibial ligament as well as that of the deltoid ligament in order to correct the rotation of the calcaneus. In some cases it may be necessary to lengthen the tendo calcaneus. Several cases of congenital flat foot have been repaired by a plication of the deltoid ligament with most satisfactory results. The youngest age was six years.

CONCLUSIONS

1. The valgus weight-bearing position of the foot is considered as an important causative factor in the pain and instability following the fractures of the ankle.
2. A simple plication of the deltoid ligament of the ankle joint will correct the valgus deformity.
3. The operation will not complicate or prevent more radical operation (arthrodesis) if such is advisable later and, therefore, should be considered as a "preliminary" operation before arthrodesis.
4. The same plication operation is indicated in the flaccid flat foot.

COMMON ALLERGIC MANIFESTATIONS IN CHILDHOOD*

HERBERT S. DIECKMAN, M.D.

EVANSVILLE

THIS paper is presented as a brief discussion of the most common allergic manifestations of childhood which are met in everyday practice. It will be my earnest endeavor to give the highlights of each condition and some practical suggestions in management. The four most common conditions, namely: eczema, asthma, hay fever, and vasomotor rhinitis, will be discussed.

ECZEMA

Eczema is mentioned first because it is usually the first allergic manifestation to be met; at least, it is one of the first to plague the doctor's existence. I am speaking now of the true allergic eczema or, as Coca names it, atopic eczema. In this condition true reagins to specific allergens can be demonstrated in the blood stream. I am not speaking of the various contact rashes, such as diaper rash, rash from antiseptics, heat rashes, et cetera.

Eczema may begin very early in life, even within the first twenty-four hours, and it usually manifests itself before the sixth month. It may vary

in intensity from a mere erythema to a severe exudative crusty type. The most common sites of occurrence are the cheeks of the face and the flexor surfaces of the arms and legs. These locations are so diagnostic that without involvement of these areas other things besides a true eczema should be looked for.

The management of this type of eczema may be simple or very complicated. It involves three major things:

1. Local management of the skin.
2. Prevention of scratching.
3. Finding the offending allergen.

Soap and water are extremely irritating and should be discontinued immediately. Mineral oil is the cleansing agent of choice. Baby oils frequently irritate because of the antiseptic. In the very acute exudative states, a boric acid or wet Burow's solution pack may be used to advantage. Occasionally lotions are useful. In the early stages only the blandest creams or oils should be used. Never use an ointment containing tar or other irritants in the acute stage. In the subacute and chronic stage, tar may be used to good advantage.

*Read on the Graduate Education Program of the Vanderburgh County Medical Society, February 24, 1949.

Prevention of scratching is of utmost importance. This requires all possible ingenuity. Local applications help. The antihistamine drugs help. Benadryl is most valuable in this case, because of its sedative effect. The fingernails must be kept well trimmed, mittens should be employed, and restraints used if necessary. It is extremely difficult to outguess a baby. A baby is more ingenious at finding ways to scratch than the doctor is at preventing it.

Finding the offending allergen may be fairly easy or very difficult. Most often the offending substance is a food. Commonly it is milk. A change from cow's milk to goat's milk, or to one of the hypoallergenic milks, or to soybean milk sometimes solves the problem miraculously. The question immediately arises. What about the breast-fed baby? Can this baby be food-sensitive when it is getting only breast milk? The answer is, of course, yes. We know that many food proteins pass through mother's milk unchanged. The most notable example is egg protein. So, if you want to continue the baby on breast feeding, the first step is to eliminate all egg from the mother's diet. However, if breast feeding is not too important, the baby may be changed to bottle feeding.

All of these things can be done in your own office and they require only time and patience. With this method of approach, you will be surprised how many babies are helped. If this method fails, then we must hunt further for the offending substance. This involves a more elaborate setup for testing. Direct testing of the skin may be employed but it is such a struggle that I use it only rarely. Here the passive transfer method is of great value. It is based on the fact that there are circulating antibodies (reagins) in the blood stream for each specific offending allergen. The reagins are found in the serum. Blood is withdrawn from the baby and the serum is passed through a Seitz filter for sterilization. Then this serum is injected intradermally into the arm of a nonallergic person. The reagins remain fixed at these sites for about two weeks. Direct intradermal testing may be done on these areas. In this fashion we find many hitherto unsuspected offenders.

ASTHMA

Asthma we think of primarily as a symptom complex found in adults. However, it is quite common in both infants and children. Asthma during infancy and early childhood differs just a little from asthma in later childhood and adult life. I want to discuss the difference. We have exactly the same pathological process at work, but due to the fact that the bony frame of the thorax is more flexible, the classical picture of the asthmatic sitting up and using all accessory muscles is absent. The child may breathe just as well while lying down as while being held up. The heat regulating center is less well developed in children and for this reason fever is not uncommon. The leukocyte count

is frequently high, with a relatively higher eosinophil percentage than in adults. The secretion of mucus and the outpouring of eosinophils is often so pronounced as to make the x-ray picture look like pneumonia. As the child grows older the asthma takes on the classical picture.

The immediate problem is to relieve the acute attack. Simple home remedies are sometimes quite effective. The inhalation of plain steam is sometimes helpful. This helps to loosen the tight mucus. I emphasize plain steam because many times tincture of benzoin and similar things are sufficiently irritating to increase symptoms. The induction of vomiting is an aid. The act of vomiting alone helps bring up the mucous plugs from the bronchi. In severe attacks adrenalin is the standby. This may be given hypodermically or by aerosol. In the very severe attacks oxygen may be lifesaving. Contrary to the old belief, children can and do sometimes die in an attack of asthma. Ephedrine, ipecac, and iodides serve well in the milder attacks. Many times the antihistamines, which have practically no effect in adult asthma, are quite helpful in children.

After the alleviation of the acute attack, begin immediately to try to find the causative agent in order to prevent recurrence. Treat the condition seriously because repeated asthma incapacitates, leads to structural changes, and to severe psychological maladjustments.

HAY FEVER

Very little need be said about hay fever. The classical symptoms are the same in infants, children and adults. In this section we have three distinct hay fever seasons: early spring from trees, summer season from grasses, and the common fall season from ragweed. You are all familiar with the symptomatic treatment of hay fever. The antihistaminics give good symptomatic relief in the milder cases. However, the importance of specific treatment cannot be overemphasized.

Specific treatment may be started at any age. A patient is never too young to start specific treatment. Children tolerate treatment very well and have no objection to repeated injections. Let me add just a word of caution. Pollen extracts are extremely potent antigens. Very careful administration is necessary in order to avoid constitutional reactions.

VASOMOTOR RHINITIS (PERENNIAL HAY FEVER)

Vasomotor rhinitis, in my opinion, is the most important allergic manifestation of childhood. It is characterized by a stopped-up nose, rhinorrhea, and itching. It is the most common of all allergic manifestations. Treat it very seriously, because if neglected the sequelae many times lead to tremendous problems.

The child is usually brought to the doctor with one major complaint—a constant cold and runny

nose. This alone makes one suspicious that he is dealing with an allergic nose. The first question I always ask is, "Show me how you rub your nose." If the child is old enough, he will respond immediately. If an infant, the mother will show you. The response is typical. It is an attempt with the palm of the hand to push the tip of the nose upward in order to obtain more breathing space. The response is so characteristic that it is called the allergic salute. Its diagnostic significance is very important. The condition is so common that if one visits the grade schools he can pick out many of the allergic children simply by watching them rub their noses.

Mere inspection of the nose gives a lot of information. Instead of seeing the normal pink mucous membrane or the fiery red membrane of infection, one sees a pale washed-out swollen membrane with a lot of clear mucous discharge. A smear of this discharge will show practically 100 percent eosinophils.

The symptoms in the beginning usually flare up as acute attacks. They have all the symptoms in the beginning of an acute cold. However, they subside so quickly that it leaves the mother puzzled, especially after a half dozen such episodes. As the condition progresses, the acute attacks become more frequent and gradually are present all the time. The frequency of the attacks or the chronicity depend, of course, on the amount of contact with the offending allergen.

The mother consults the physician because she realizes that there is something more serious than just a common cold. At this stage the family physician has a golden opportunity to help. It is not difficult to recognize the allergic character of the condition. Don't dismiss it as merely a runny nose, of little or no consequence, because serious difficulties develop as the condition progresses over the years. Take a careful history. Many times this will give you the answer. These attacks may be coincidental with a visit to grandmother's house. Further questioning may reveal that grandmother has a cat. Exposure of the child to the cat brings on an attack. There is your answer. Or the mother says the child won't eat this or that. Many times this is a clue because a child is like an animal who instinctively learns to avoid harmful things. Eliminate the common offenders, feathers, dogs, cats, chocolate, wheat, eggs, milk, et cetera. There are adequate substitutes for eliminated foods. If the elimination works, expose the child again to see if you can reproduce symptoms. If you can, the problem is solved. If simple eliminations do not solve the problem, further investigation is necessary. Skin testing should then be employed. A child is never too young to be tested. If direct testing is not advisable, passive transfer testing may be done.

It is important to persist in order to avoid the sequelae which are both physical and mental. The

first complication that usually arises is a cough from a postnasal drip. This drip is the result of mechanical blocking. The mucus can't get out the front door, so it goes out the back door. Then polyps begin to develop. A polyp is nothing more than mucous membrane that has become so waterlogged that it cannot return to its normal state. The pathological process has become irreversible. These polyps require surgical removal. With prolonged nasal congestion actual bony changes may take place, resulting in definite facial deformities. The unchecked contact with sensitizing agents frequently leads to the very serious complication of asthma.

The most serious complication, in my opinion, is the effect it has on the mental outlook of the child. The child does not feel well. No one can feel well with a continuously blocked nose. This feeling of being unwell is quite vague to the child and he is unable to express his difficulties adequately. As a result, he becomes inattentive, loses his appetite, and makes mistakes that any ordinary healthy child does not make. As a result, he is punished. The punishment makes him cross and irritable. He becomes nervous, upset, withdrawn into himself, and in short, a problem child. It is not uncommon for the mother to say that the child is unmanageable. When school age is reached, the problem becomes acute. The child doesn't adjust well in school. He doesn't learn and is left behind, which only increases his problems. About this time a psychologist is frequently consulted and to everybody's amazement the child's I.Q. is either normal or above average. Then why doesn't he do well? The answer is that he doesn't feel well because his nose is stopped up. With the removal of the offending allergens and a clearing of the nose, there is a remarkable transformation of personality. The mother smiles as she very happily states that this is an entirely different child. This is not a fantastic tale. It is an everyday occurrence in the practice of an allergist.

In these days when psychosomatic medicine is so much talked of, I wish to advance one physical reason for behavior disturbances in children. Do not misunderstand me. Psychosomatic medicine plays an important part in the field of allergy but this is one place in which I feel the position is reversed.

Although I have discussed four clinical allergic manifestations in childhood, do not be under the impression that these are four separate and distinct entities. The conditions frequently overlap or one may succeed the other. The child must be studied not as a case of eczema or asthma but as an allergic individual, remembering that the clinical manifestation is only the end organ affected. The process is the same whether it be eczema, asthma, hay fever or vasomotor rhinitis. Take the problem of the allergic child seriously, and treat the child as a whole and not as a single clinical entity.

PNEUMOTHORAX DUE TO PULMONARY INFARCT: A REPORT OF TWO CASES†

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THE medical literature of the day is replete with cases of so-called spontaneous pneumothorax attributed to the rupture of an emphysematous bleb. Mediastinal emphysema has also been described in a number of cases and attributed to the same etiological factor. Cases of traumatic pneumothorax, either with or without penetrating injuries of the chest wall and with or without fractures of ribs or costal cartilages, have also been described, and among other etiologies mentioned in the literature as causing pneumothorax have been:

(a) Various operative procedures involving the chest or abdomen, during which injury to either the visceral or parietal pleura may result in pneumothorax. Outstanding among these is the induction of artificial pneumothorax, during which nicking of the pulmonary parenchyma frequently produces a more extensive pneumothorax than was actually anticipated.

(b) The tearing of adhesions binding the lung to the chest wall, either by operative means or due to trauma.

(c) Rupture of an area of compensatory emphysema following some strain, such as coughing, et cetera—the emphysema usually being secondary to an area of atelectasis elsewhere.

(d) Softening and rupture of a sub-pleural caseous tuberculous focus, in younger individuals, or rupture in older individuals of an emphysematous bleb near a fibro-ulcerative area of tuberculosus.

(e) Softening and rupture of a lung abscess.

(f) Softening and rupture of an infected pulmonary infarct.

(g) Softening of a pneumonic process with secondary rupture and pneumothorax.

The possibility of a noninfected pulmonary infarct undergoing aseptic necrosis with resultant rupture and pneumothorax has apparently, however, not received much attention in the past. This author, in a review of the medical literature for the past thirty-five years, has been able to find only seven such cases reported to date, and these will be touched on rather briefly at a subsequent point. The purpose of this paper is not, however, to pre-

sent a review of the literature on this subject but rather to bring forth two additional cases in which the causal relationship between an antecedent pulmonary infarction and a subsequent pneumothorax appears fairly well (if not conclusively) established and to entertain the thought that this relationship may not be as rare as we have been lead to believe in the past. With these preliminary remarks, we now turn to our case reports.

CASE 1

This sixty-year-old, acutely ill, white male was admitted to the Veterans Administration Hospital, Indianapolis, for the first time on October 24, 1939, the patient having experienced the day before a sudden attack of severe pain in the right lower abdomen which had radiated into the right hip and down the right leg. On admission there was elicited a history of dyspnea on exertion, irregular heart action, limited exercise tolerance, and occasional precordial pain (not particularly related to exertion or relieved by rest) of six years duration. The pertinent physical findings at this time were diminished skin temperature and absent arterial pulsation below the groin in the affected extremity; auricular fibrillation; a soft mitral systolic murmur; generalized arteriosclerosis; and slight hepatomegaly. Laboratory studies (blood counts, urines, N.P.N., blood sugar, Wassermann, et cetera) were all within normal limits, but the EKG showed auricular fibrillation, myocardial damage, and right axis deviation. The chest plate showed a normal cardio-thoracic ratio with a mitral configuration to the heart shadow. Improvement followed bed rest and supportive measures, and at discharge the color and warmth had returned to the right lower extremity as also had the popliteal and dorsalis pedis pulsations.

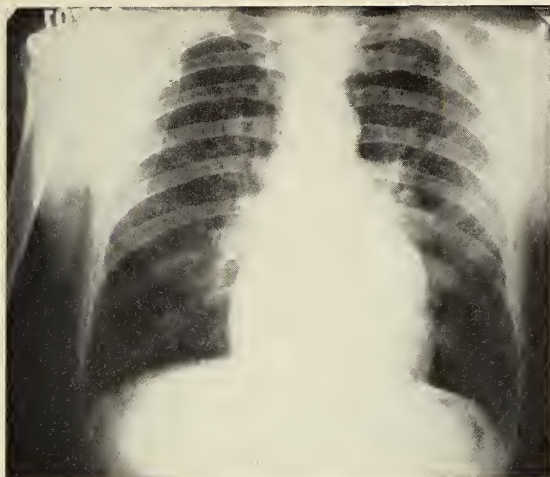
He was readmitted on May 3, 1941, in cardiac failure (as manifested by the presence of ankle, pretibial and paraspinal edema; some venous engorgement in the neck; moderate dyspnea at rest; basal pulmonary rales and cardiac enlargement on percussion). The blood pressure at this time was 160/100; slow auricular fibrillation was present, and a blowing mitral systolic murmur was audible, but no presystolic murmur could be detected. An x-ray of the chest at this time revealed an increase in the size of the cardiac shadow (as compared with previous film) as well as signs of chronic passive congestion in both lungs. The electrocardiogram showed essentially the same findings as on the previous admission, and other laboratory studies were essentially negative. The history on this readmission was that largely pertinent to congestive failure. In addition, there was now obtained a history of rheumatism of several years duration, with migrating pains and aches in many of the joints of the body but no clear-cut picture of fever or of associated swelling, heat or redness. Under digitalis and diuretics, the patient once more improved.

The patient's third admission took place on January 11, 1942, and the symptoms and physical findings at that time were much the same as those on the previous admission. Although quite ill on admission, he responded well to treatment. However, at discharge, which took place on March 5, 1942, at his own request and against

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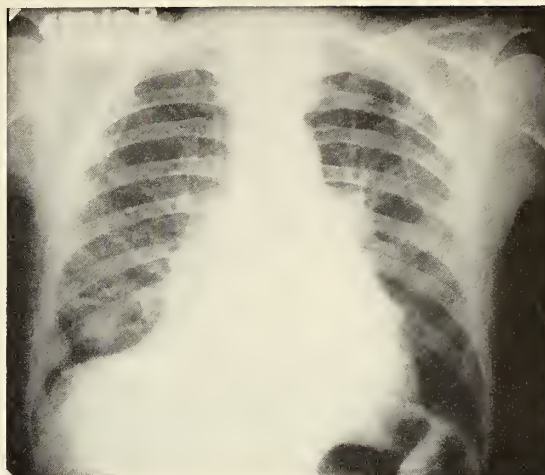
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Figure No. 1



Case I—Chest film obtained during the patient's first admission, illustrating the mitral configuration of the heart shadow with normal cardio-thoracic ratio.

Figure No. 2



Case I—Roentgenogram of the chest obtained during the patient's third admission, illustrating increase in the size of the heart shadow and evidence of chronic passive congestion of the lungs.

medical advice, some evidence of congestive failure was still present. During this hospital stay the patient complained of pain in several joints of the body and did actually manifest swelling and heat in the right knee joint as well as heat and pain in the right ankle, both of these persisting for three or four days and disappearing under moderate doses of salicylates. The possibility of an acute rheumatic arthritis with concomitant cardiac damage was raised at this time, but the absence of any fever, and the absence of any elevation of the sedimentation or pulse rates, or of any changes in the electrocardiogram appeared to militate against this possibility, particularly since x-rays of the spine showed definite arthritic changes. Other laboratory studies were essentially negative except for an elevation of the white count, which soon disappeared after the patient improved.

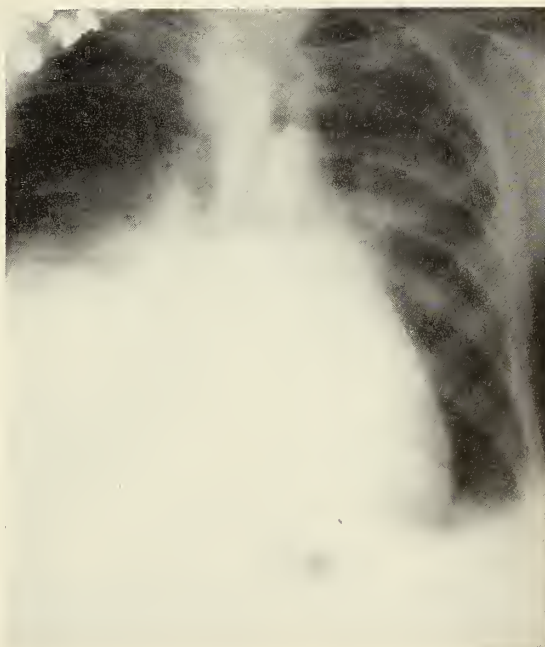
The patient's fourth and final admission was on June 14, 1942, (the patient then being sixty-three years of age). Once more the symptoms were those referable to cardiac decompensation and much the same as on previous admission. In addition, there was now noted basal dullness over both lung fields, but more particularly over the right base, where dullness and diminished breath sounds extended to above the angle of the scapula. As the patient had some slight blood-streaking of the sputum, the possibility of a pulmonary embolus was held likely. Treatment was promptly instituted, but the patient failed to improve as desired. In addition, he developed a psychosis, became uncooperative, refused his medicine, would not eat, was noisy and restless. Laboratory studies at that time were all negative except for a N.P.N. of 54.

On June 24, 1942, the patient suddenly appeared much more dyspneic and somewhat more cyanotic than previously. His pulse was more rapid and although his blood pressure remained the same (130/100), he seemed in obvious distress. Over the right lung there was dullness to flatness over the lower half of the right chest, with tympany above that level and absence of breath sounds throughout the lung, but no mediastinal shift. The diagnosis of hydro-pneumothorax was made and confirmed by x-ray. The patient was promptly tapped and 700 cc. of cloudy yellow fluid and considerable air, under pressure, were removed, with much improvement in the patient's clinical appearance and disappearance of some but not all of the physical findings. The next morning all the chest findings had returned and, in addition, the edema, cyanosis and cardiac decompensa-

tion were more marked than ever before. A pleural tap at this time released considerable air under markedly positive pressure, as well as 700 cc. more of fluid. Improvement was only very brief; within a half hour the patient was again in as much distress as ever before. Surgical intervention for the pneumothorax was considered but, in view of the patient's obviously moribund condition, was vetoed by the surgical service. The patient expired that same day in the early afternoon.

On postmortem examination the most striking findings

Figure No. 3



Case I—Chest film obtained June 24, 1942, shortly after the patient developed clinical evidence of a pneumothorax. Note the presence of air and fluid in the right hemi-thorax and mediastinal displacement to the left.

were, of course, the complete collapse of the right lung, the presence of a large amount of blood-tinged fluid in the right pleural cavity, and the complete absence of adhesions between the right lung and parietal pleura. In the lower lobe and also in the lower portion of the upper lobe of the right lung there were areas of consolidation, these having the appearance of moderately recent infarcts. In the lowest of these was a perforation which easily admitted the end of a good-sized hemostat (this obviously being the source of the pneumothorax). The left lung was negative except for a small area of consolidation in the upper lobe. The liver showed some evidence of chronic passive congestion. The right kidney showed several small, old, healed infarcts. The heart weighed 600 grams and was definitely enlarged. The pericardial sac was adherent to the anterior surface of the right auricle. The myocardium appeared intact, and the tricuspid and pulmonic valves showed no changes. The mitral valve was calcified and stenosed to such an extent that it would not admit one finger. The aortic valve was slightly incompetent, owing to outward folding of the edges of the valve. There was a large mural thrombus in the left auricle. The coronaries were patent; the aorta only slightly atheromatous. The remainder of the postmortem examination was uninformative and the source of the pulmonary infarcts could not be determined.

CASE 2

This 33-year-old white male was first admitted to the Veterans Administration Hospital, Indianapolis, on July 27, 1943, complaining of dyspnea on exertion and ankle edema of six weeks duration. Past history was uninformative other than for the usual childhood illnesses and an attack of chorea at the age of 13. Approximately two months prior to admission the patient was involved in an accident during which he sustained a fracture of the left side of the arch of the fifth cervical vertebra for which he received treatment elsewhere with an apparently uneventful recovery. Some six weeks prior to admission here the patient gradually developed increasing dyspnea, orthopnea, and dependent edema, and on July 3, 1943, was hospitalized elsewhere, and a diagnosis of rheumatic heart disease with cardiac decompensation was made. At that time the EKG was reported as showing auricular fibrillation and cardiac damage, while x-ray of the chest showed a cardio-thoracic ratio of 17/31 cms. with a cardiac silhouette characteristic of mitral disease. In addition there was evidence of chronic passive congestion noted in both lungs, as well as an area in the right base suggestive of an infarct. The x-ray of the cervical spine demonstrated an irregular fracture of the left side of the arch of the fifth cervical vertebra, apparently healing with no significant displacement of the fragments. Despite digitalization, the dyspnea gradually increased, and some hemoptysis and dependent edema became manifest. Some forty-eight hours prior to the patient's transfer to this hospital, there apparently occurred a sudden and rather marked aggravation of the dyspnea, so that this now became by far the most striking symptom present.

On admission here the pertinent physical findings were the presence of marked dyspnea and orthopnea even at rest; hepatomegaly (the lower edge of the liver coming almost to the umbilicus) with, however, downward displacement of the upper border of the liver; engorgement of the jugular veins; some tortuosity of the peripheral vessels; dullness over the right base posteriorly to about the level of the sixth dorsal vertebra and over the right axilla to the level of the third interspace, with hyperresonance over the right apex anteriorly; almost absent breath sounds throughout the entire lung; marked cardiac enlargement to the left on percussion and palpation; a presystolic apical thrill coupled with presystolic and systolic murmurs of rather characteristic quality; cardiac irregularity. No deviation of the mediastinal structures

Figure No. 4

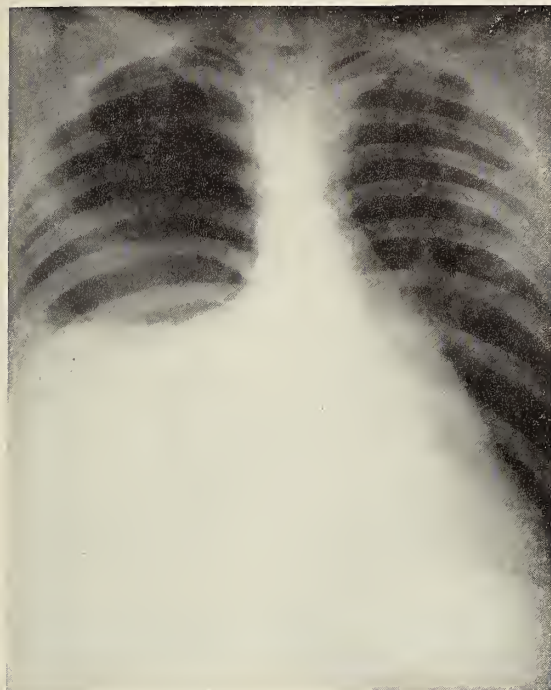


Case II—Chest film obtained July 3, 1943 (at another hospital), which demonstrates a fracture of the left side of the arch of the fifth cervical vertebra and a mitral configuration to the heart shadow. Note the evidence of chronic passive congestion in both lungs, as well as the area at the right base, rather suggestive of a pulmonary infarct.

was noted. The x-ray of the chest at that time showed a right hydro-pneumothorax and a complete collapse of the right lung. A thoracentesis was performed the same day and 1800 cc. of air under pressure removed, with the result that the patient became more comfortable. He was digitalized and started on cardiac management. On July 29 it was again necessary to tap him, 3,500 cc. of air being removed. Positive pressure was no longer observed at this time, the initial reading being minus 1 plus 1, and the final reading minus 3 minus 1. Following this second thoracentesis and the institution of cardiac management, the patient gradually began to improve, although the pneumothorax persisted and the lung re-expanded only very gradually, so that by January 1, 1944, it was still occupying only about one-third of its original volume. Laboratory studies done during this interval (including N.P.N., blood sugar, serum amylase, icteric index, van den Bergh, several urinalyses, fractional bromsulfalein, repeated blood counts, et cetera) were all essentially negative, with the exception of the electrocardiographic changes, which were similar to those noted before; a Wassermann which was positive on one occasion but negative on two subsequent rechecks; and a somewhat elevated white count. It was the clinical impression at this time that the patient was suffering from far advanced rheumatic mitral stenosis and insufficiency with fibrillation, and that he had had a pulmonary infarct which had softened and ruptured, and that the hydropneumothorax on the right side was secondary to the infarct.

The patient's progress for the next several months was satisfactory but slow, the signs of cardiac decompensation gradually lessening and the dyspnea and orthopnea, while still present, becoming gradually less severe. On December 8 the patient began to run a low-grade fever up to 102, which continued throughout December

Figure No. 5

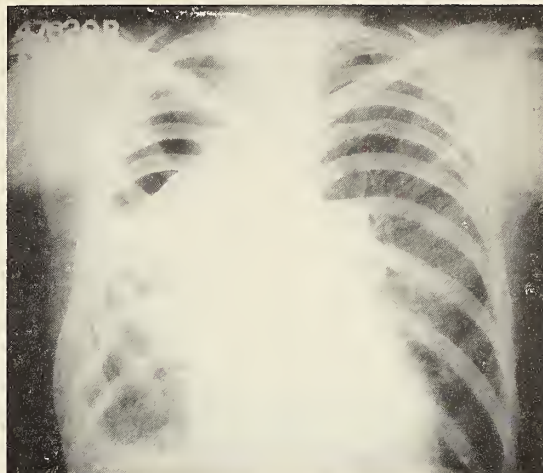


Case II—Chest film obtained July 28, 1943, on admission to Veterans Administration Hospital, Indianapolis. Note the hydro-pneumothorax on the right, with complete collapse of the right lung.

15, and then subsided. On December 24, 1943, the patient again became febrile and for the next two weeks continued to spike up to 102 daily, this rise in temperature being accompanied by weakness, sweating, and inspiratory pain in the right side. Thoracentesis on January 1, 1944, revealed the presence of thick pus in the right pleural space. Similar material was noted on expectoration, making the diagnosis now pyopneumothorax with bronchopleural fistula. The absence of fever or purulent pleural fluid during the several months this patient had been under observation prior to this time indicated that the pyopneumothorax was due to a secondary contamination of a previously sterile hydro-pneumothorax and not the result of the breakdown of an infected pulmonary infarct.

On January 7, 1944, the patient was taken to surgery and a right-sided thoracotomy was performed. Post-operative convalescence was satisfactory and by February 29, 1944, fluoroscopy showed only a small pocket of fluid at the lower third of the right lung with some tenting of the diaphragm and some further expansion of the lung. Repeated sputum studies during this time, as well as guinea pig inoculations, both from sputum and pleural fluid, were all negative for the presence of acid-fast bacilli. By March 22, 1944, the patient had improved to the point where consideration could be given to further surgery, inasmuch as the right lung had shown very little further expansion in the interim and inasmuch as adhesions binding the right lower lobe to the chest wall, which had been demonstrated on several previous occasions, were still found to be present. The chest consultant, however, was of the opinion that the patient constituted too great an operative risk, and further medical management was decided upon. The patient remained in the hospital until January 6, 1945, being treated in the meantime by rest, digitalis, and supportive measures, and during this period there was

Figure No. 6

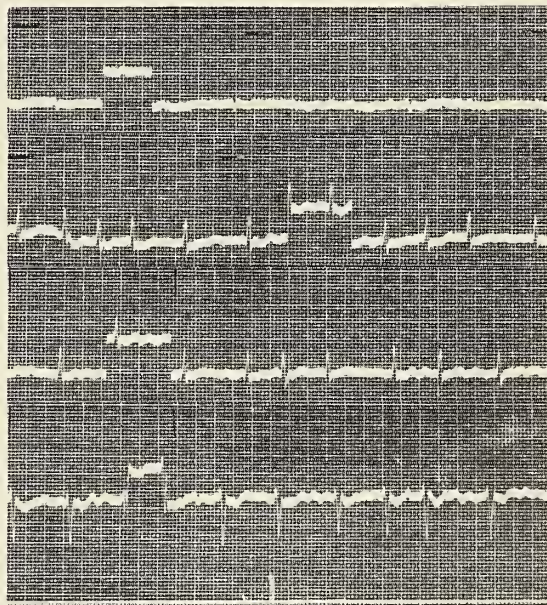


Case II—Chest film dated November 14, 1944. Note the marked re-expansion of the right lung which has occurred in a period of sixteen months. A partial pneumothorax still persists.

considerable reexpansion of the right lung and almost complete cessation of drainage, so that by the time of discharge the right lower and middle lobes were of almost normal volume, while the upper lobe showed from 40 percent to 60 percent reexpansion. However, considerable increased density was noted throughout the entire upper right lung on roentgenogram, and it was felt that considerable fibrosis had taken place.

On July 27, 1945, the patient returned to the hospital because of a severe infection of the right hand,

Figure No. 7



Case II—Electrocardiogram dated July 27, 1943, obtained on the patient's first admission to Veterans Administration Hospital, Indianapolis. Note the right axis deviation and the presence of auricular fibrillation.

caused by a human bite some six days prior to admission, followed some two days later by signs of cardiac decompensation. On admission, the pertinent physical findings were those relative to the infection of the right hand and to cardiac decompensation. The thoracotomy scar was healed at this time and the pulmonary findings were those of dullness throughout the entire right lung, with diminished breath sounds over the lower half of the right lung and bronchial breath sounds over the right apex posteriorly. In addition, numerous crepitant rales were audible over both bases posteriorly. X-ray of the chest showed considerable increase in density throughout the right lung with an elevated right diaphragm and the cardiac silhouette of mitral disease. Because of the urgency of the case and the failure of the patient's infection to respond to penicillin, an amputation of the right middle finger was performed under local anesthesia after preliminary digitalization. For a few days thereafter the patient seemed to be doing fairly well, but on August 21 he developed signs of increasing dyspnea and cardiac failure, and an x-ray taken the following day showed extensive infiltration throughout the right lung and a fluid level at the right base, the impression being that of a recent pneumonic process involving the right lung superimposed on pre-existing pulmonary fibrosis. The patient's course thereafter was consistently downhill and fatal termination occurred on August 25, 1945, permission for a postmortem being refused.

COMMENT

The causal relationship between the antecedent pulmonary infarction and the subsequent pneumothorax which followed it appears self-evident in the first of the two cases offered for consideration here. One can be excused for harboring some reservation relative to the clarity of our evidence in the second of these two cases. Certainly with a history of antecedent trauma some two months prior to admission here, the question must be raised of whether this patient might have had a traumatic pneumothorax which was not picked up earlier. In refutation can be offered only the fact that an x-ray of the chest taken at another institution some five weeks after the patient's accident failed to disclose any pneumothorax but did show findings suggestive of a pulmonary infarct. To this can be added the fact that the patient's dyspnea increased rather dramatically and rather markedly in intensity some two days prior to admission here, making it seem likely that this was the time that rupture took place. These findings, coupled with an obvious etiological factor for the production of pulmonary emboli, lead us to include this case as a second instance of pulmonary infarction followed by aseptic necrosis of the infarcted area and subsequent pneumothorax even though we do not have conclusive proof, either from postmortem findings or from films taken immediately prior to the onset of the pneumothorax.

In addition to our two cases, we find seven additional instances of this condition reported in the literature. These are shown in tabulated form elsewhere in this article. One of these cases (that of Marks) is included in this tabulation with some misgiving, inasmuch as examination of the sputum showed a few suggestive acid-fast organisms on

one occasion. The finding of acid-fast organisms, however, was not confirmed by subsequent sputum examinations or guinea pig inoculation. A second case reported by Marks in this same publication⁵ is not included in this tabulation. This is a case of pneumothorax following by some eighteen days an extensive infarct of the right middle and lower lobes in a 24-year-old male who was also found, at postmortem, to be suffering with a toxic myocarditis and pericarditis and an adrenocortical adenoma. In this case tension pneumothorax was also found, but at postmortem the infarcted area was found to be gangrenous and the gas escaping from the opened pleural space foul-smelling, while the pleural fluid was seropurulent. It is true that the history suggests that this infarct was initially sterile and that secondary contamination and gangrene took place when the lung tissue lost its viability. Nevertheless, the presence of a definite gangrenous area prevents our including this case with others demonstrating the thesis that *aseptic* necrosis of a pulmonary infarct may result in pneumothorax.

It is interesting to note that of the total of nine cases so far reported, seven of the nine occurred in males, the youngest of these being a case (reported by Myers) of a 17-year-old boy whose pulmonary infarct involving the left lower lobe followed a thrombosis of the right internal and external iliac veins, as a complication of ulcerative colitis, and was in turn followed after a period of nineteen days by a pneumothorax under positive pressure. The oldest of the cases so far reported was that of our 63-year-old male, where rheumatic heart disease was the predisposing factor. Of the remaining seven cases, the age range was from 26 to 44 years of age and the mean age apparently between 34 and 35. Of the seven other cases reported, the leg veins are definitely incriminated as a source of embolism in five cases and the heart in two, and in our two cases the source of the embolus would appear to have been cardiac in both instances. Seven of the nine cases reported were diagnosed as having cardiac pathology of one sort or another and in six of the nine cases, including one of ours, a definite tension pneumothorax was found. The size of the infarct and the location of the infarct appear rather variable, but the time of occurrence of perforation appears to be fairly consistent between nine and twenty-one days after infarction has occurred. Exitus is usually the outcome in most of these cases, particularly if a tension pneumothorax is produced, largely because these cases are poor risks to begin with and are ill disposed to withstand the additional burden so imposed upon them. Our thoughts along this line are strengthened by the fact that of the three cases which did survive at least until the pneumothorax had completely or largely disappeared (cases of Daniels and Rogers and the second of our two cases) a tension pneumothorax was present in only one of the three and this in a 20-year-old white

ANALYSIS OF DATA OF REPORTED CASES†

Case	Sex	Age	Underlying Condition	Source of Embolism	Location of Infarct	Size of Infarct	Size of Perforation	Time of Occurrence of Perforation	Tension Pneumo-Thorax	Pleural Fluid
Daniels ¹	M	20	Typhoid	Leg	L	-----*	-----	-----	Yes	None
Guggenheim ²	F	37	Coronary Dis.	Leg (?)	R		Size of a lentil	12 days	-----	Serous
Hayashi ³ No. 7	M	37	Cardiac Infarct	Rt. vent.	RLL	Large	Large	-----	Yes	Serofibrin
Hayashi ³ No. 8	F	40	Nephritis, lft. ventr., hypertr. rheum. mitral dis.	Leg	RUL	-----	-----	-----	-----	Serofibrin
Marks ⁴	M	17	Ulcerative Colitis	Leg	LLL	Large	-----†	19 days	-----	Serous
Rawson and ⁵ Cocke	M	39	Rheum. aortic dis., femoral phlebotrombosis	Leg	LLL	Entire Lobe	6 cm. (diam.)	3 weeks	Yes	Bloody
Rogers ⁷	M	44	Hyperten. ht. dis., card. infarct, apical aneurysm	Rt. vent	RLL, LLL, RML	Largest 4x4x3 cm.	-----†	9 days	No	Serous
Sales No. 1	M	63	Rheum. mitral stenosis	Rt. heart (?)	RLL	Large	Large	10 days	Yes	Serofibrin
Sales No. 2	M	33‡	Rheum. mitral stenosis	Rt. heart (?)	R	-----*	-----	-----	Yes	None

* No autopsy.

† Perforation not demonstrated at autopsy.

‡ Age at which pneumothorax occurred.

Modified from Rawson and Cocke.

male who was apparently in good health other than for the typhoid infection from which he was suffering at the time that infarction occurred. It appears that if these cases do withstand the immediate insult, they are always subject to the danger of subsequent infection of the pneumothorax, particularly if the bronchopleural fistula persists for any length of time and a pyoneumothorax is thus produced, creating an additional difficult problem in management. In the second of our two cases, the patient apparently survived the immediate episode only to develop an extensive pulmonary fibrosis which became more and more evident as the contracted lung gradually expanded.

Also worthy of note is the episode of "rheumatism" which the first of our two patients had while in the hospital under observation, at the age of 62, and which in retrospect certainly appears to have been a typical episode of acute rheumatic fever. In view of the considerable literature on the subject of the frequency of rheumatic heart disease in the elderly and the demonstration by several authors that episodes of acute rheumatic fever in the aged are by no means rare, this finding in our case is certainly not astonishing. The finding of a calcified mitral valve in our first case is merely another example of a condition which has received increasing recognition of late and which is being demonstrated more and more frequently clinically by proper fluoroscopic and roentgenological technique. Undoubtedly our second patient would have demonstrated a marked calcification of the mitral valve, as well, had he too come to postmortem.

Before closing, we wish to call attention to another case reported in the literature which does not fall directly into the group under discussion here, but which shows several points of similarity to that group. This is a case reported by Miller in 1937 of a normally delivered, four-day-old, male infant who suddenly became dyspneic and markedly cyanotic, and on x-ray manifested a right tension pneumothorax with marked displacement of the mediastinum to the left. In this case, despite

constant suction drainage of the pneumothorax by an indwelling catheter, the infant's condition deteriorated rapidly and death followed two days later. At postmortem the striking findings were the complete absence of the right pulmonary artery and a large necrotic area in the right lung which had perforated, producing the pneumothorax. The left pulmonary artery was perfectly normal in this case, but the ductus arteriosus was patent, as also was the foramen ovale, while the pulmonary veins were small on both sides. Miller offers as explanation of the etiology of this case the failure of the right sixth aortic arch to develop and states that this infant was apparently able to survive in utero because the circulation from the bronchial arteries was sufficient for the limited pulmonary function, but that necrosis resulted when the lungs became inflated after delivery. Miller contends further that the bronchial arteries are apparently sufficient to maintain life in adulthood but that in the infant and the young child the increased metabolic demands are such that the absence of a pulmonary artery as in this case proves rapidly fatal.

SUMMARY

Two cases of pneumothorax following aseptic necrosis of a pulmonary infarct are described here. The thought is held out that a causal relationship between these two conditions (pulmonary infarction and pneumothorax) is not as infrequent as popularly believed.

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NOTICE OF AMA MEMBERSHIP ASSESSMENT

(Clip this form and mail with your check today if you have not already done so.)

The American Medical Association has requested your county medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association—Assessment* and mail to the secretary of your county medical society.

To The American Medical Association, Debtor
Special Assessment \$25.00

....., M.D.
Name

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County

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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THE AMERICAN MEDICAL ASSOCIATION ASSESSMENT

ACCORDING to a report released by Dr. George Lull, Secretary of the A.M.A., Indiana is twenty-sixth in the list of associations ranked according to the percentage of members who have paid the twenty-five-dollar assessment to the American Medical Association. This represents payment by 68.4 percent of the members of the state association.

This is not a record of which we should be ashamed, but it could be improved upon. From the outset it was recognized that not all members of the association would be in a position to pay the assessment. Interns, residents and young doctors who are not fully established in their practices have been counseled not to consider it as one of their obligations. Our members who are now in military service and the honorary members of the association have not been expected to contribute, although some of them have.

Included in the group who have not paid the assessment are those doctors who disagree with the aims of the Education Campaign, and others who disagree with the A.M.A. plans for combating the federalization of medicine.

There is also a group of doctors who, while they are vigorously opposed to government control of medical service and recognize the necessity of combating the trend toward socialism, may at first have had honest doubt as to the wisdom of creating a large fund, and may still question the effectiveness of the A.M.A. campaign.

For this group the most significant fact in the

A.M.A. report is the position in the percentage list of the state of California.

The doctors of California were challenged by the threat of state medicine and compulsory insurance several years before the threat grew to comparable proportions throughout the United States.

The doctors of California accepted the challenge and answered it in the same way that the American Medical Association is dealing with the national challenge. Long before the A.M.A. special assessment was levied, the profession of that great state raised expense money out of its own pocket, and conducted a state-wide campaign which was eminently successful, and which in many respects is the model for the A.M.A. Education Campaign.

The \$25.00 assessment and the National Education Campaign is a new thing for most of the doctors of America. Neither of these is new to the physicians of California. They have tried them both before on a state basis, and are continuing their own state campaign.

Today, after having given heavily to their own local cause and after having toiled on their own education campaign, the California Medical Association leads the nation in the payment of the assessment, with a towering percentage of 85 percent.

This record was made by men who have contributed before, who have seen their money spent for the purpose of educating the people, and who know that it has done the cause of free medicine a tremendous good.

FINANCIAL SECURITY

VARIOUS bodies of professional persons are now interested in a movement to amend the federal income tax law. This law now permits corporations to establish pension trusts for their employees, and to deduct from taxable income all sums paid into the trusts. The owner or owners of a corporation may be classified as employees for the purpose of establishing such pension trusts.

An inequity is created by the law, in that no such provision is allowed professional men and others whose incomes are attributable to personal services.

The present high tax rates make it practically impossible for a professional man to provide a proper amount of financial security for old age and retirement. Under the prewar schedule of rates it was possible for a financially successful taxpayer, during his peak earning period, to make provision for his security in later years.

The corporate pension trusts are a wise provision of the law. Since income taxes are paid only when the money is withdrawn from the trust, the tax bracket which is applicable in any one year is that which is commensurate with the individual's living costs. Professional people at the present are doubly taxed, in that a high bracket is applied to income which is saved for the future. If savings for old age could be exempted from taxation during the year in which they are laid away (as is the case with corporate employees), the income taxes to be paid when the savings were withdrawn and used would fall within an equitable bracket.

One proposal which has been suggested to remedy this situation is to amend the tax law so as to permit persons with earned income to purchase a limited amount of non-negotiable government bonds, the cost of which would be excluded from income for tax purposes. Later the proceeds would become taxable as income in the year in which cashed.

Agitation for a change in the federal law is not a request for special privilege, but merely an attempt to do away with the inequity which the present law creates between corporate employees and self-employed persons who derive their living from the performance of personal services.

This would make a good subject for every physician to discuss with his congressional representative. Many congressmen are members of the various professions, especially the legal profession. They are in the same income tax-paying category as are most physicians and should be able to understand the problem.

ATTENTION—ALL GENERAL PRACTITIONERS

ELSEWHERE in this issue is reprinted a report by Dr. M. B. Casebolt, chairman, A.M.A. Section on General Practice, of his impressions of the Cincinnati convention of the American Academy of General Practice. Defects in our system of medical education are pointed out and their correction analyzed. To quote,—“How much weight will a surgeon . . . or other specialist carry when he advises his admirers of the student level to become general practitioners? The answer would seem to be that qualified successful men in this field must be permitted to develop a program which will appeal to the students within the curriculum of the teaching centers.”

It is indeed encouraging that efforts are being made to eradicate the blight on general practice by attacking its etiology. How indeed can a medical student form a decent idea of general practice when his only contacts are specialists and full-time professors?

“UNNECESSARY HUMAN SUFFERING”

IN HIS three thousand word report, President Truman *re* his ten-year health program stressed compulsory health insurance and indicated that this is necessary to end “unnecessary human suffering.”

Even an intelligent layman knows that much of the total load of human suffering is psychological and not in any way connected with physical ills—not amenable to medical care.

Particularly should the layman who has reached the highest office within the reach of the United States citizen be able to appreciate the psychological strain placed upon the citizenry by a profligate government moving toward totalitarian policies with taxes already ten percent higher than the limit for survival.

The people endowed with average intelligence know that the quickest and surest way to lighten the heavy load of “unnecessary human suffering” is to end the New Deal.

A check of the Federal government's present medical load would show that the mounting neuropsychiatric phase has long since outstripped the physical. In this country we have moved along with our so-called civilization only to find that sniping bureaucrats are much harder on the nerves than mauling Indians.

How healthful and how helpful it would be if Mr. Truman would show some disposition to clean house and cut costs.—Editorial, *Journal Oklahoma State Medical Association*, August, 1949.

Editorial Notes

IMPRESSIONS OF THE AMERICAN ACADEMY OF GENERAL PRACTICE CONVENTIONS

MILTON B. CASEBOLT, M.D., Chairman, A.M.A.
Section on General Practice

For thirty-five years medical education has revolved around specialized training. Gradually, the practical clinical professor in teaching centers has been replaced by the full-time research type of instructor. Medical knowledge has been divided into a multitude of departments, with overlapping of corresponding fields, to the extent that the student is bewildered and confused as to just what he is supposed to know when he graduates from his four-year exposure to numerous research problems.

He is informed that he will have to get all the practical applications in his hospital internship. Here again he meets with neurosurgical, orthopedic, urologic, laboratory, and medical procedures designed for the rare type of disease. With pen in hand he prescribes x-rays, intravenous fluids, complete laboratory work-up and antibiotics, many times before a complete history and physical examination. The hospital staff mount their professional horses and ride in so many directions at the same time that it is difficult for the young doctor to gain perspective as to what properly balanced medical care really is.

It is not the purpose of your reporter to discredit the educators or to cast reflection on the integrity of medical teaching in our schools, but rather to call attention to the fact that an undue amount of subject matter is crowded into the curriculum, in the name of science, which is not related to the practical. It is little wonder that medical values become distorted and lost.

All problems which appear highly complicated are usually due to the lack of grasp of the fundamentals or are due to incomplete information. The correct diagnosis involves simple mental processes. The things one can *hear, feel and see*, if correctly interpreted, will lead to the right conclusion most of the time.

It is the belief of many general practitioners that the correlation and integration of medical knowledge may be as important as mastery of isolated facts. Each part of the whole must be evaluated and assigned to its proper place and

assembled to give a complete picture of any educational project.

Those who are well informed in things medical state that approximately 30 per cent of the young physicians should be directed in special fields, and 70 per cent in the general. If this be the proper proportion, the general practitioners should consider the general applications in their field and bring into play related facts in diagnosis and care of the sick. When the need arises, the proper specialist can be made available for both practitioner and patient.

New techniques and procedures may have to be developed to maintain the proper balance and equilibrium in medical practice. Certainly a re-emphasis must be placed on the role of the family doctor in medical care and teaching. If the student does not *hear, see, or feel* the idealism of the general practitioner in his undergraduate years, how can he be expected to be one? How much weight will a surgeon, eye, ear, nose and throat or other specialist carry when he advises his admirers of the student level to become general practitioners? The answer would seem to be that qualified successful men in this field must be permitted to develop a program which will appeal to the students within the curriculum of the teaching centers.

In pursuance of this thought, the Congress of Delegates went on record at the 1949 American Academy of General Practice convention as recommending a department of general practice in all medical schools.

The logical question arises—how can this be accomplished without disrupting the present educational system? Will there be two programs of instruction—one for the young physician preparing for a specialty, and another for the general practitioner? We are now on one of the frontiers of medical thought, and the best minds of the profession are exploring the field. There is no doubt that an answer will be found.

The American Academy of General Practice, with ten thousand members, and so rapidly receiving applicants that it cannot keep up with its enrollment, also speaks for thousands of other doctors who believe this project is of vital concern and relates to the future of medicine. The ways and means are not entirely clear, but the 70 per cent have found a voice and feel they have a just cause.

Medical centers all over the country report that their refresher and postgraduate courses are well filled with general practitioners eager to keep abreast of the newer developments. Is this a renaissance? The spirit, attendance, and atmosphere of the Cincinnati convention seemed to indicate a *crusade*—a movement by family physicians for equality of opportunity and action.—*Jackson County Medical Society Weekly Bulletin*, Kansas City, Mo., April 16, 1949.

President's Page

SERVICE—OUR WATCHWORD!

THE centennial convention is now over, and what a grand celebration it was! Congratulations to Doctor Hauss, and Dr. J. Neill Garber, and to all committees.

Now let us look forward to a new century of progress. We are all living in a turbulent and uncertain world, and our thoughts are torn between fear and faith. Let us all emphasize the faith way for our own peace of mind, and continue to advocate good principles and fairness to all mankind.

Let us keep our leadership in all phases of life, especially medical leadership, and set a pattern for the rest of the world, instead of following other countries who have failed so utterly.

We as medical men need to contact all legislators in the county, state and nation, to tell them our medical needs, so the people will have good medical care. We as medical men need to promote good public relations with each of our patients, friends, and the general citizenry. This can be done by rendering "Service." There is no better time to get a favorable response from people than when they are sick and in trouble. We all crave good treatment, sympathy and kind words.

Let us all alert ourselves to politics and see that candidates are nominated and elected on the various tickets who will be concerned with the best interests of the people and fair with the medical profession. Let us all lean over backwards to "Serve"—to create better public relations, so the public will know we have its interests at heart, as well as our own.

If we follow the above suggestions, I am sure we will make the public honor the medical profession, and support us in our endeavors.



Medical Panorama by the ASSOCIATE EDITOR

LIVING WITH A COLOSTOMY

"Sixteen Years With a Colostomy" has Dr. E. C. Dubois, of Springfield, Massachusetts, lived, according to his article thereon in the *Connecticut State Medical Journal* for September 1949. In these days of more frequent surgery on the colon, this paper is timely and contains much sound advice based on personal experience.

"There is too little understanding that this operation requires not only physical adjustment but mental adjustment as well. It is all very well to encourage these patients by citing numerous examples of people in all walks of life, normally active despite this handicap, but it would help considerably more if they were schooled in the pitfalls most likely to be met. We see many cripples on the street, and it is evident that there must have been a long period of time before they gained enough confidence in themselves to go out alone in public, and that this depended not entirely on the nature of their injury, but on their own acceptance that they must learn to live with it. Therefore it is a great help for colostomy patients to know each other. 'Ask the man who owns one' is not only good advice in buying a car but applies also to learning how to live with a colostomy. There is nothing in the world like swapping experiences. Although I tell my patients that some daily system should be followed, I do not tell them that it will be fool proof. In other words I advise them that perfect control of a colostomy is uphill work, and that there will be moments highly annoying, to say the least.

"* * * As to the technique of washing out the colon, one needs only a douche bag (or a 2 quart hot water bottle), 2 quarts of warm water, a 26 F. catheter and an enameled basin 14 inches in diameter. The patient sits astride the toilet bowl holding the basin upright between the thighs to avoid splashing, the catheter is inserted in the stoma and the water flowing in and out evacuates the fecal matter into the toilet bowl. This cannot be hurried and should be taken when one has undisturbed possession of the bathroom for one hour; one half hour for the washing, fifteen to thirty minutes for the final seepage to empty the colon. For patients who have considerable flatus, one half teaspoon of bismuth daily is recommended. * * * The main thing in regard to diet is to eat at regular hours, avoid anything between meals, and cut the calories to individual needs. Indeed the amount of food is quite as important as the kind. There is an old saying that large eaters are never constipated and there is no doubt that the less one eats the better will be the colostomy control. Most people have no difficulty with meat, bread and potatoes, but must try out gradually their ability to take care of vegetables and fruits. There are certain foods that stimulate peristalsis to an extraordinary degree, which one must take with caution, if at all. I mention in particular maple syrup, molasses, and brown sugar; vegetables with considerable fibre, as carrots, cabbage, turnips, corn and spinach. * * * Any deficit from the lack of essential foods can be supplied by vitamins in medicinal form.

"In regard to colostomy apparatus, I discourage my patients from using anything except a pad of cellu cotton overlaid with oiled silk or the material from which

shower curtains are made, held in place over the stoma by a belt or adhesive strips. This is cheap, disposable and odorless, and can be changed with a minimum of inconvenience. Everyone who has had a colostomy for any length of time has experimented with stoppers of various sorts. All are irritating if used every day or over long periods of time, and particularly are they harmful unless they leave some vent for the escape of gas. A finger cot stuffed lightly with toilet paper or cellu cotton, tucked into the opening and held by the pad, makes a very good temporary expedient most useful at times."

The original article is well worth reading, as it deals with the patient's morale and suitable psychotherapy. Truly, experience is still the best teacher.

FURTHER POINTERS ON BREAST CANCER

Only by eternally hammering at it can we overcome inertia (in ourselves as well as others) in the matter of early diagnosis of cancer. Examination of the breasts is simple, yet too frequently slighted. Helpful is this outline, by Jelks and Kennedy in the September 1949 *Journal of the Florida Medical Association*:

"In the examination of a patient's breast, the classical signs of cancer must be discarded and minimal changes looked for. Inspection and palpation will give the information necessary for arriving at a diagnosis, and, therefore, transillumination and roentgen study are not routinely employed.

1. Inspect the breasts with the patient in the sitting position; note any difference in the size of the two breasts, difference in the height of the nipples, retraction of the nipple, any bulging or dimpling. We do not see nipple retraction as an early finding.
2. Palpate the breasts with the flat of the hand and with the finger tips. Determine the location, size, shape and consistency of the tumor.
3. Examine the breasts with the patient in the supine position, using both inspection and palpation as described.
4. Try to demonstrate skin attachment by the use of side lighting or a slanting light and gentle manipulation of the tumor with the fingers from all sides. Often we have been able to demonstrate dimpling by this method when we could not do so with a direct overhead light. The mobility of the tumor and the skin over it is thus carefully determined. We consider dimpling as an early sign and one to which we attach great significance.
5. Examine both axillae and supraclavicular areas carefully.

"In the final analysis, any lump in the breast deserves a biopsy in the operating room with a rapid microscopic determination by a competent pathologist. Preparations should be made for the radical operation, and this should be carried out immediately if the report of the tissue examination is one of malignant disease."



CLAUDE S. BLACK, M.D.

Warren

PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1949-50

CLAUDE S. BLACK, M.D.

PRESIDENT

INDIANA STATE MEDICAL ASSOCIATION

1949-50

DR. CLAUDE S. BLACK, of Warren, succeeded to the office of president of the Indiana State Medical Association on September 29, 1949, at the close of the annual convention.

As the association began its second century of medical service to the people of Indiana, Doctor Black, in assuming the office, announced that the watchword for his administration would be "Service."

Doctor Black's term as president-elect was busy and eventful, and was itself a culmination of the many duties he has performed as a physician and as a citizen throughout his professional life. His watchword "Service" is well chosen; he has served his own community and the medical profession untiringly, and thereby brings a wealth of experience and wisdom to the high office of president.

Doctor Black was born in Huntington County, July 19, 1880. He attended rural schools and Warren High School, and later taught a one-room rural school. After attending Indiana University, he entered Indiana Medical College, and graduated with the M.D. degree in 1905. He spent seven months in postgraduate work in New York City. He began the active practice of medicine in Warren in 1905 and, with the exception of time spent in military service in World War I, has practiced there ever since.

He married Hallye Nelson, a native of Putnam County, on November 16, 1910. They have one daughter, Miss Suzanne Black, who is a business teacher in Parker Vocational High School, Dayton, Ohio.

He is past president of the Huntington County Medical Society and of the Eleventh District Medical Society. He has also served several terms as councilor for the Eleventh District. Other duties for the state association include secretaryship of the Section on Medicine, chairmanship of the Section on General Practice, chairmanship of the Committee on Indigent Medical Care, and membership on the Committees on Scientific Work, Prevention of Traffic Accidents, and for Study of Lay Activity in Medical Practice. He has been a member of the Advisory Board of the State Welfare Committee, and a director of the Mutual Medical Insurance, Inc.

On behalf of the members of the Indiana State Medical Association, THE JOURNAL wishes Doctor Black a happy and successful administration. May each one of us accord him the same kind of conscientious work and support which has characterized his own stewardship for medicine in the past.



ISMA's giant birthday cake was presented to patients at the Riley Hospital after its appearance at the gala centennial banquet, by Dr. Augustus P. Hauss. The batter for the cake weighed 130 pounds; the icing weighed 70 pounds; a total of 200 pounds. It was 3 feet in diameter and 3½ feet high.



Seated at one of the tables designated for past presidents and their wives were (left to right): Dr. and Mrs. Charles N. Combs, Terre Haute; Dr. and Mrs. George Daniels, Marion; Dr. and Mrs. N. K. Forster, Pacific Palisades, California; Mrs. C. H. McCaskey, Indianapolis; Mrs. and Dr. E. E. Padgett, Indianapolis; and Mrs. and Dr. J. E. Ferrell, Fortville.



Dr. C. H. McCaskey, of Indianapolis, was guest of honor at a luncheon at the Indianapolis Athletic Club during the centennial session, given by physicians who had lived in Doctor McCaskey's office while in medical school. He was presented with an antique clock. Dr. Lordan came from Los Angeles to be present at this reunion.

Front row (left to right): F. E. Keeling, J. K. Lordan, C. H. McCaskey, H. D. Lynch, H. D. Pyle. Back row (left to right): W. K. Sennett, R. U. Leser, S. L. Bryan, J. W. Griffith, M. L. McClain, W. M. Cockrum, J. K. Leasure, R. J. McQuiston, Alfred Ellison.



Dr. Charles S. Bond, of Richmond, age 93, the oldest living past president of the state association, greeted Dr. Claude S. Black, of Warren, who had just been installed as president, when they met at the centennial banquet at the Indiana Roof.

PROGRAM FOR MIDWEST REGIONAL MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS

Claypool Hotel

Indianapolis, November 19, 1949

9:00 A.M.—“The Differential Diagnosis of Hyperthyroidism Using Radioiodine,” E. C. ALBRIGHT, M.D. (Associate), Assistant Professor of Medicine, University of Wisconsin Medical School, Madison, Wis.

9:20 A.M.—“Cholesterol Metabolism in Health and Disease: Its Relationship to Clinical and Experimental Arteriosclerosis,” J. STAMLER, M.D. (by invitation), Research Associate, Department of Cardiovascular Research, Michael Reese Hospital, Chicago, Ill.

9:40 A.M.—“The Diabetic Kidney,” ROBERT JOSEPH SCHIFFLER, M.D. (by invitation), Medical Director, St. Joseph's Health Resort, Wedron, Ill., and FRANCIS D. MURPHY, M.D., Professor of Medicine, Marquette University School of Medicine, Milwaukee, Wis.

10:00 A.M.—“Present Status of the Modified Insulins,” F. B. PECK, M.D., Associate Director of Division of Medicine, Eli Lilly and Co., Assistant Professor of Medicine, Indiana University School of Medicine, Indianapolis.

10:20 A.M.—“Metabolic Effects of ACTH,” J. W. CONN, M.D., Associate Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Mich.

INTERMISSION

10:50 A.M.—“The Treatment of Pernicious Anemia and Other Macrocytic Anemias with Vitamin B₁₂,” D. C. CAMPBELL, M.D., Consultant in Medicine and Instructor in Medicine, and BRYON E. HALL, M.D., Consultant in Medicine, Mayo Clinic, Associate Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minn.

11:10 A.M.—“Folic Acid Antagonists in the Treatment of Adults with Acute Leukemia,” FRANK H. ETHELL, M.D., Assistant Director of Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan Medical School, Ann Arbor, Mich.

11:30 A.M.—“The Treatment of Polycythemia Vera with Radio-active Phosphorus: a Ten-year Study,” B. K. WISEMAN, M.D., Professor of Medicine, The Ohio State University, Columbus, Ohio.

11:50 A.M.—“Studies of Erythrocyte Survival,” H. E. HAMILTON, M.D. (by invitation), Associate; R. F. SHEETS, M.D. (by invitation), Instructor; and E. L. DeGOWIN, M.D., Associate Professor of Medicine, State University of Iowa, Iowa City, Iowa.

LUNCHEON

2:00 P.M.—“Differential Diagnosis of Ventricular Paroxysmal Tachycardia,” RICHARD

LANGENDORF, M.D., Associate Physician, Michael Reese Hospital, Chicago, Ill.

2:20 P.M.—“Advantages of ‘Unipolar Leads’ in Electrocardiography and Some Important Considerations Concerning the Technique of Taking Them,” F. D. JOHNSTON, M.D., Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Mich.

2:40 P.M.—“Observations on the Pulmonary Circulation in Man,” H. A. ZIMMERMAN, M.D. (by invitation), Teaching Fellow, Department of Medicine, and ROY W. SCOTT, M.D., Professor of Clinical Medicine, Western Reserve Medical School, Cleveland, Ohio.

3:00 P.M.—“Diagnosis and Management of Multiple Pheochromocytomas: Case Reports,” HOWARD A. LINDBERG, M.D., Associate in Medicine; NEWMAN V. TREGER, M.D. (by invitation), Research Assistant in Medicine; FRED W. FITZ, M.D., Assistant Professor of Medicine; and KNOWLTON E. BARBER, M.D. (by invitation), Assistant Professor of Urology, Northwestern University, Chicago, Ill. (Illustrated by movie in color.)

INTERMISSION

3:30 P.M.—“Tissue Storage of Mercury and the Anatomical Findings Following the Prolonged Administration of Organic Mercurial Diuretics or Mercuric Chloride,” R. N. HARGER, Ph.D. (by invitation), Professor of Biochemistry; and H. R. HULPIEU, Ph.D. (by invitation), Professor of Pharmacology, Indiana University School of Medicine, Indianapolis.

3:50 P.M.—“The Use of Diuretics in the Treatment of Congestive Heart Failure,” F. JANNEY SMITH, M.D., Physician in Charge, Cardio-Respiratory Division; and ELLET H. DRAKE, M.D. (Associate), Division of Cardiology, Henry Ford Hospital, Detroit, Mich.

4:10 P.M.—“The Use of Low Sodium Diets in the Treatment of Hypertensive Disease,” J. MARION BRYANT, M.D. (by invitation), Assistant Professor of Internal Medicine, and ELAIRA BLECHA, M.S., Dietitian in Charge of Outpatient Dietetic Clinic, University of Michigan Medical School, Ann Arbor, Michigan.

4:30 P.M.—“Mechanism of Hyperthermia Not Due to Infection,” MAX M. MONTGOMERY, M.D. (Associate), Assistant Professor of Medicine; FORD K. HICK, M.D., Associate Professor of Medicine; and ROBERT W. KEETON, M.D., Head, Department of Medicine, University of Illinois, College of Medicine, Chicago, Ill.

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

EXPERTS DIAGNOSE STATE MEDICINE

Doctors may disagree in many cases but when 3,711 Indiana practitioners, in consultation in their state convention, put in \$20 each to fight socialized medicine there can be no doubt as to their diagnosis of the seriousness of the case. If the doctors say state medicine will be a bad thing, that is convincing evidence.

It is not a case of selfish interests with the doctors. They would not be put out of business if bureaucracy were to take over, as it has in Great Britain and some other countries. They know, however, what socialized medicine has done to efficiency. Experience has shown that under socialized medicine costs are greatly increased and service to the patient deteriorates. Why ask our doctors to be under the system that they know is a wasteful failure elsewhere? If you were ailing and all the best doctors you know agreed on what should be done, would you take the advice of some political quack who insisted on bleeding you?

—*The Indianapolis Star*

BACK DOOR TO STATIST MEDICINE

With members of the Indiana State Medical Association in Indianapolis this week to celebrate their great organization's centennial, it is an appropriate time to note the growth of medical care for war veterans in the last 100 years—also the time to propose that there are limits to all things.

In 1849 young America had a large number of war veterans, including those of the then recent Mexican War. But there were no veterans' hospitals or other facilities in those days. Both in the field in wartime and on the home front in peacetime, medical care for the nation's fighting men was abominable. It was better, but not enough better, a half-century later. It took World War I to bring about an adequate response to the obligations due the sick and wounded survivors.

At the end of the first World War there were 4,000,000 veterans. Today there are 18,733,000 and the ramifications of the problem have increased accordingly. The Veterans Administration operates 126 hospitals and other facilities, and new ones are either in the construction or planning stage. Indiana has three hospitals. A new \$8,000,000, 500-bed structure in Indianapolis will be ready for use in 1951 and a 200-bed institution will be located in Fort Wayne. The Federal government's VA hospital bill in this state alone is now \$10,600,000 a year.

Despite this enormous expansion of facilities the

126 present VA hospitals are constantly overcrowded. Why? The reason lies in the tremendous increase in non-service-connected cases. In 1925, a year after the present policy of hospitalizing veterans with non-service disabilities was started, five of every six patients had service-connected disabilities. In January, 1949, only one in three fell in this category.

The nation can never fully meet its obligation to the men and women whose disabilities were a consequence of war service. Literally, "nothing is too fine" for them. But we believe far more stringent limitations will have to be placed on non-service-connected cases or VA hospitalization will mushroom out of all proportion to the obligations involved. It is a potential back door to socialized medicine—an evil which Indiana's and the nation's doctors are valiantly resisting.

—*The Indianapolis News*

THE PHYSICIAN'S SIDE

For a long time the nation's physicians maintained a dignified, and unrealistic, silence as the proponents of government medicine smote them hip and thigh.

The gist of the attack was that medical men, despite good intentions, were falling down on the job; the nation needed more comprehensive medical services, and the best way to obtain them was through compulsory insurance.

And it is ironical that the most articulate spokesman for this precinct in Mr. Truman's welfare state was a Hoosier, Oscar R. Ewing, Federal Security administrator.

Mr. Ewing made a good case for government-subsidized medicine—that is, if one overlooked certain serious flaws in the plan. These flaws were well known to the nation's doctors, but it was not until the last six months that they wisely decided they must speak out as a group against the federal plan. The American Medical Association first took up the cudgel, and then passed it on to the state medical societies.

Indiana's doctors demonstrated how thoroughly they are opposed to government medicine in their state convention which just closed the other day. The physicians subscribed to a war chest, not in the spirit of self-protection as much as in a belief that state medicine would be of incalculable harm to their patients. Hoosier physicians know that government-administered medicine is like all panaceas—it promises a lot but the results are invariably disappointing.

—*The Indianapolis News*

The following statement of policy has been adopted by the Madison County Medical Society, in order to affirm the belief that the medical profession has the right and duty to examine critically and express opinions concerning proposed legislation, whether it deals with the socialization of medicine, with the general trend toward socialism, or with the trend away from socialism.

STATEMENT OF POLICY OF THE MADISON COUNTY MEDICAL SOCIETY

YOUR DOCTOR is convinced that the attempt to establish federal control of medical practice is only one part of a sinister plan to socialize this country. Your Doctor, therefore, opposes the socialization of medicine, not as a single threat to your freedom, but as a part of a totally un-American scheme. He is opposed to all proposals which would enable the socializers to accomplish the destruction of this greatest of all nations.

It has been suggested by the socializers, of course, that Doctors are opposing the proposed legislation because it would mean a financial loss to them. Nothing could be farther from the truth, for in reality the proposed legislation would not mean reduced incomes but would increase the income of the medical profession.

Doctors are opposing such legislation because they know that it will hamper and restrict:

FIRST: Their free and heretofore unquestioned privilege of giving their individual patients the kind of care which they feel to be best, without regimentation and interference by political restriction.

SECOND: Their right to feel individually responsible to their patients and to no one else for the care of their patients' health.

THIRD: Their right to feel that their patients have freely chosen them, and that they have freely accepted the responsibility for the individual person coming to them for care.

These are basic principles of the free practice of medicine which has given to the American people the highest standard of medical protection in the world today. These principles now are under direct threat of destruction by the socialization of medical practice as proposed by compulsory health insurance plans.

Your Doctor has unlimited confidence in you, his patients. He knows you do not want socialism or communism. He is certain that if you know the truth about the health insurance proposals in Congress, the socializers will never be able to destroy our country.

The Madison County Medical Society, of which your Doctor is a member, feels it should state the principles by which all such proposals will be measured.

The Medical Society will oppose any legislation which:

1. Increases regimentation of the individual citizens of this republic.
2. Limits individual opportunity.
3. Restricts individual attainment.
4. Reduces incentive for individual enterprise.
5. Increases federal spending.
6. Increases federal taxation.
7. Increases federal bureaus.
8. Makes the individual dependent on the federal government.
9. Places unjust or unequal restriction on individuals or groups of individuals.
10. Tends to limit the rights of the individual as guaranteed by the Constitution to life, liberty and the pursuit of happiness.

The Medical Society will support any measure which:

1. Reduces or removes regimentation of the individual by the federal government.
2. Increases opportunity for the individual without obligation to the federal government.
3. Permits the individual to achieve the highest attainments possible.
4. Encourages individual enterprise.
5. Reduces federal spending to a sensible level.
6. Reduces federal taxation.
7. Reduces the number or decreases the size of federal bureaus.
8. Fosters the true American ideals which stress the importance of the individual in determining policies of State, instead of the government making the individual subservient.
9. Reduces inequality of opportunity between individuals and groups of individuals.
10. Simplifies the federal government and stresses return to fundamental constitutional principles.
11. Returns to local government units those functions which are declared local responsibilities by the Constitution.
12. Will enable the individual to advance upon his own merits as rapidly as possible, independently of any organization or group to which he may belong.

Released by the Committee on Publicity,
Indiana State Medical Association

Youth Speaks to America

SOCIALIZED MEDICINE—DEMOCRATIC?

BEVERLY ANNE PHILLIPS

CAMBRIDGE CITY

IN THE course of a few million years humanity has had its doctors—every kind from its very early witch doctors, who were supposed to have frightened ills out of the body, to its present expertly trained, well prepared M.D.'s. During that period medical science has done very well by itself without aid from any other source.

Young men and women do not go into the medical profession with their hearts set on getting rich in a hurry—probably their aim is merely a reasonable living as their only money-value reward. The real reward they hope to gain is the satisfaction of saving human lives, of caring for those who are ill. It matters not to them whether their patient is a multimillionaire or whether he is the lowliest, penniless waif who begs in the streets.

Some people believe that doctors work only for those who pay well. That is a false, misleading belief. I happen to be the great-granddaughter of a doctor, as well as a granddaughter of a doctor. My grandfather is a fine, sweet, beloved, old gentleman who has been practicing medicine for nearly fifty years, and who in that time served as a Captain in the United States Army in World War I. Except for this time with Uncle Sam, he has been a devoted country doctor who has been serving the same rural community for the past forty-two years. Not only did he give medical aid, but he also found time to sit down and have heart-to-heart talks with young and old, helping them to solve all sorts of problems. He has been a friend to all and everyone who has known him has had great confidence in him and what he did. Many, probably most of his patients, were not at all well-to-do. Many could not pay for medical services when rendered. Many more could never hope to pay for *any* services but still, knowing that he would receive no remuneration, he plodded out in the worst wintery weather at all hours of the day or night to go deep into the hills, to even the filthiest, most miserable huts, through which the snow and wind blew as if through a barn, to comfort the sick or perhaps to bring a new life into the world. He is no longer able to do much work. He has given his life to humanity. His reward in money was meager but his reward in satisfaction—that of saving lives and bringing more than 2,000 infants safely into the world—has done far more for him than any bank account could ever do.

This is only one example, but it is typical of the average American doctor. He, although it will not affect him, does not approve of socialized medicine. When there are sick to be cared for that is all that matters to a doctor; not the question, "Am I going to get paid for making this call?" No, no

doctor could be that hard-hearted. Perhaps there are a few exceptions—aren't there to all rules? But these exceptions are probably the well-known "quacks" who are working for their own personal gain. I personally have yet to see a doctor refuse to treat someone who is really in need of medical aid, no matter what he himself must sacrifice. My granddad gave up his only daughter, who died while he was away giving his service to his country, saving the lives of others—maybe your own father, son, or brother. If you think that is not a sacrifice, think again.

A doctor in his present profession has something to work for, to work toward, to gain. He has the desire to experiment, to learn new methods, to do research work, to practice as he sees fit. In socialized medicine the doctor is told who his patients may be, how much he will get per year, the hours he is to work, et cetera. Is that democratic? Indeed it is not!

If the government wishes the rich and poor to be treated alike why doesn't it supply additional funds for the purpose of giving medical aid to the very poor? Or still a better method: In the brief study of income tax in government and economics in high school we learned, "The people are taxed on their ability to pay." Why not practice a little of this method in medicine? Charge patients according to their ability to pay. That will insure equal aid for all and it can be done with very little criticism. Doctors can estimate their patient's ability to pay and I am certain that for the good of their own practice they would not charge anyone unreasonably large amounts.

Following are a few questions and brief discussions to create and stimulate a little consideration of the subject:

1. Do you find that our M.D.'s favor Socialized Medicine?

Very few, if any. I believe the whole decision of whether or not America has socialized medicine should lie in their hands, since they are the ones whom it will extensively affect.

2. Is it democratic?

If you say it is, give just *ONE* good reason why.

3. Will it encourage youth to enter the medical profession?

Very few young people have sufficient funds to get them through twelve years of public school, and then six or more additional years of college, which are required in the medical profession. In socialized medicine what is there to work for after the student has worked

his way through at least part of his schooling—what is there awaiting him? Probably a whole life of slavery with the government's hand on his weary shoulder demanding him to do this and not to do that.

4. Will it encourage medical science to continue to expand its research or will it stifle it completely?

Put yourself in the doctor's place. I doubt that you'd have the desire to try to do much of anything under socialized medicine. Keep in mind that American doctors are human and deserve to enjoy the freedom and equality that are outstanding benefits to all people of a democracy. When they no longer can enjoy that freedom, then neither shall America remain a democracy.

5. Will it actually give the poor a better chance for medical care? If so, how?
6. Would its adoption cause other of our fine democratic American ways and customs to be eaten up by socialism?
7. Would it bring about a healthier and happier mankind?
8. Would it bring our America into a closer union or would it tend to disunite and tear her apart?

To some this article will bring a good, hearty laugh, especially when I tell you that I am but a recent high school graduate, having graduated in May of 1947. You say I don't know what I'm talking about, I'm too young to know what it's all about, I'm talking through my hat. If you do get a laugh out of it, I hope you enjoy it to the utmost. But for your information this article was not written for the purpose of being humorous—not to any degree. It just so happens that I am one of a few million of America's youth who realizes that we are tomorrow's citizens, that we've got to clean up a world that has been riddled by a generation of blood-thirsty peoples who have piled a large load of rebuilding the entire world and returning it to its normal state on our young shoulders. It is my earnest belief that socialized medicine will only cause more trouble in the already over-troubled world. Medical science has done very well for itself in the many years it has been constantly developing and improving. Why, then, should it be tampered and interfered with now?

Some think we "kids" are just a bunch of little hoodlums and dumbbells, taking up space in American homes and on her streets. I might remind you that many boys my age and even younger, whom I've known and grown up with, have gone out to fight a battle which somebody else started. They went making little complaint. Lots of them are back now; some OK, some never to be completely well again, some have not come back yet, some will *NEVER* come back. Rather straight-forward, isn't it? It is the cold, honest, down-to-earth truth—whether we like to accept it or not. Somehow I can't forget this; neither can the rest of my gen-

eration—that survived. My only brother and countless other American boys are still serving their country, striving to protect and maintain the peace and freedom which we so recently have regained—the freedom of American democracy, the freedom that permits our American doctors to save our very lives and to keep us well. The American doctor played a major part in bringing victory to America in the recent national emergency. If he was in the service he worked ceaselessly saving the lives of these fellows; yes, all of those who could be saved. If he was at home he knew no rest for he did not only his own work but worked all hours of the day and night striving to help overcome the acute shortage of medical aid here on the home front. In either case, both did their duty to the very best of their ability—and they did it very well, without socialized medicine, too.

These teen-age soldiers who went to war were old enough to fight in an inhuman hell to save America, but lots of them, so says the law, are still not old enough to vote for the things which they so nobly and valiantly fought for. Perhaps if American youth had a little more chance to voice its opinion on current national affairs, was given a greater responsibility in regard to home, community, and country, and was permitted the right to vote at the age of 18, we might find ourselves becoming better citizens and leaders for the world tomorrow. We were old enough to give our all in war; give us a fair chance in peace.

Likewise these American doctors fought to gain for us the freedom we all love so much. They fought, too, to maintain their own free enterprise. They, too, gave their all in war; they, too, want their freedom in peace.

The Constitution of the United States of America, whose preamble begins with these three little but mighty words, "WE THE PEOPLE," was written by the able fathers of our country some 200 years ago. Through these almost two centuries it has been a most satisfactory document in executing our American form of government. Its democratic ways of living have advanced America to the point where she is the envy of all who see her. Why should we, then, allow the evils of socialism or any other "ism" to enter our democracy, to undo 200 years of hard work, to cripple and mangle it—an ill from which it could not recover? An ill which neither socialized medicine, nor any other kind, could possibly cure? That is by far too great a price to pay.

Let's keep our "WE THE PEOPLE" spirit alive and not allow our land of free and equal opportunity to be swallowed up by a few politicians, with their vague ideas on how to run other people's business when they haven't yet found a successful way to run their own. Only in its present democratic freedom will American medical science continue to develop, improve, and excel. Let's give it a fair and square chance; it's a challenge to you, America.

News Notes

INDIANA UNIVERSITY POSTGRADUATE COURSES

Indiana University School of Medicine has announced definite dates for two of its postgraduate courses this fall.

The Course in Obstetrics and Gynecology will be conducted for five full days, November 14 through 18, on the same general plan which was used for a similar meeting last year. Instruction will be given in clinics, both operative and medical, in ward rounds, and in lectures. A fee of \$50.00 will be charged.

Dr. John Parks, professor of obstetrics and gynecology at George Washington University School of Medicine, Washington, D.C., will speak on Friday night, November 18, at the medical school auditorium. His subject will be "Lesions of the Vulva." This paper will be given as a part of the OB-GYN course, but this particular meeting will be open to physicians in general, without fee.

The Pediatrics Postgraduate Course will be given on four Wednesday afternoons, November 2, 9, 30 and December 7. Clinics, lectures and demonstrations will be utilized. The fee for the course will be \$5.00 per day.

Enrollment for each course is limited to 30. Interested physicians are urged to enroll as soon as practicable. Inquiries may be directed to The Dean, Indiana University School of Medicine, Indianapolis.

TWO MORE SCIENTISTS SUE HEARST FOR LIBEL

Two more libel suits have been filed against the Hearst press as the result of the vicious and reckless anti-medical campaign carried on by the Chicago *Herald-American* against the Illinois animal procurement bill which was being considered by the state legislature this spring.

This brings the number of actions to five and the total amount sought to \$3,100,000.

The two scientists striking back at Hearst in these most recent suits are Dr. C. C. Pfeiffer, head of the department of pharmacology at the University of Illinois and secretary of the Illinois Society For The Protection of Medical Research, and Dr. Elihu Bond, a veterinarian and superintendent of the animal hospital at the University of Illinois.

The first three suits on behalf of Dr. Virgil Moon, Dr. N. R. Brewer and Mr. Donald E. Dickason have been well reported in the press. This is considered exceptional since libel suits are not customarily given much notice.

A. M. A. WITHDRAWS ACCEPTANCE OF SULFA DRUG

The American Medical Association Council on Pharmacy and Chemistry has withdrawn its acceptance of sulfathiazole and sulfathiazole sodium.

Further question of the need for continuing acceptance of sulfathiazole was raised in view of the fact that less toxic sulfonamide drugs and penicillin and streptomycin are now available. In conformance with its policy of withdrawing acceptance of a toxic drug when a less toxic but equally effective agent becomes available, the council voted to omit sulfathiazole and sulfathiazole sodium from the 1949 edition of New and Nonofficial Remedies.

BLUE CROSS-BLUE SHIELD INDIVIDUAL CONTRACTS

Announcement that the Blue Cross-Blue Shield Plans will, for the first time, extend membership to individuals on a "Health Statement" certificate was made here today by officials of the hospital and doctor-sponsored prepayment plans.

Issuance of the new certificate will extend membership on a direct-pay basis to persons who are self-employed, unemployed, retired, or employed by firms with less than five employees. A signed health statement will be required of applicants for membership under the new certificate.

Until now, membership has been available only through the place of employment on a payroll-deduction basis or through community groups whose members make quarterly payments at a local bank.

The constantly increasing demand for membership coming from persons not eligible through either of the above groups led the boards of directors of the two plans to authorize issuance of the Health Statement membership.

In addition to the usual provisions for hospital, surgical and obstetrical care, the new plan provides for medical care payments for hospital patients. A broader schedule of payments for x-ray service in the doctor's office is likewise provided. Because of these broader provisions and because of the greater collection expense for direct-pay members, a slightly higher fee schedule will apply to members under the new certificate.

In the five years since the Indiana Blue Cross Plan was incorporated, over 440,000 members have enrolled. In its three years of operation, the Blue Shield Plan has enrolled 325,000 Hoosiers, all of whom are also Blue Cross members. The national Blue Cross enrollment is over 34,500,000.

NATIONAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

All members of the association are invited to attend the National Conference of County Medical Society Officers, which will be held Thursday evening, December 8, 1949, at the Hotel Statler, Washington, D. C. The Grass Roots Conference is sponsored by the Board of Trustees of the A.M.A., and is carried on by county medical society officers. A. M. Mitchell, M.D., of Terre Haute, is national chairman.

MATERNAL MORTALITY RATES DROP AGAIN FOR 1948

A continuation of the downward trend in maternal mortality shown by rates of 1947 is indicated by provisional figures for 1948 collected from state public health agencies by the American Medical Association. "The United States undoubtedly will show a rate of not more than 1.2 maternal deaths per thousand live births in 1948, a drop of 0.1 from the previous year," according to an editorial in the October 1 *Journal of the American Medical Association*.

The Indiana Association of the History of Medicine held a meeting on October 9, in the Assembly Room of Eli Lilly and Company, in Indianapolis, commemorating the Osler Centennial. Lawrence Reynolds, M.D., of Detroit, addressed the group on "Sir William Osler, the Man and His Influence on Medicine." Doctor Reynolds was a personal friend of Osler, and exhibited several of his unpublished letters.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essay submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Houston, Texas, March 9, 10 and 11, 1950, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East St. Vrain Street, Colorado Springs, Colorado, not later than January 15, 1950. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author, if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association.

CIVILIAN PHYSICIANS IN JAPAN

The Department of the Army is urgently in need of physicians to serve in a civilian capacity with the occupation forces in Japan. Minimum acceptable qualification requirements are a degree in medicine, plus five years of progressive professional experience which includes one year of rotating internship in an accredited hospital.

The salary for these positions is \$6,235.20 per year, plus 10 per cent post differential, with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain for a minimum of two years. Transportation is furnished to and from Japan. Dependents may join the employee in approximately eight to ten months after his arrival in the command.

Healthwin Hospital of South Bend has recently been enlarged and remodeled, at a cost of more than \$1,500,000. Dedication ceremonies on September 18 were attended by 600 persons. The principal speaker was Dr. Ernest E. Irons, president of the AMA. Dr. R. L. Sensenich and Dr. Stanley A. Clark were honored as the only living members of the original board of managers of the hospital.

Approximately \$700,000 has been allocated for heart research this year by the American Heart Association and its affiliates.

A group of eleven leading radiologists and health physicists represented the United States at a three-nation conference on radiation tolerances held at the Canadian Atomic Energy Establishment at Chalk River, Ontario, September 29-30.

Grants totalling \$489,584 to continue the financing of 35 research projects on mental and nervous disorders, and grants totalling \$2,554,556 made for training personnel in psychiatry, neurology, clinical psychology, psychiatric nursing and psychiatric social work, were announced recently by Federal Security Administrator Oscar R. Ewing.

All grants were approved by Surgeon General Leonard A. Scheele of the Public Health Service, upon recommendation of the National Advisory Mental Health Council.

Training Grants included \$10,638 to Indiana University and \$3,600 to Purdue University.

Dr. E. O. Nay, of Terre Haute, has recently published (Moore-Langen Printing Co.) a 512 page volume on genealogy entitled "Genealogy of the Nay Family, A Record of the Descendants of Jacob Nay of Virginia from 1723 to 1949, with Supplement." The idea of such a work arose at a family reunion in 1939. Doctor Nay was assisted by his wife, who not only aided in compilation but also did all of the typing. There is a family record of 3,777 persons, and an index of 6,430.

Dr. A. F. Weyerbacher, of Indianapolis, treasurer of the Indiana State Medical Association, has been re-elected president of the Indiana Social Hygiene Association.

At a recent meeting of the North Central Branch of the American Academy of Urology, **Dr. William N. Wishard, Jr.**, of Indianapolis, was elected president-elect, and **Dr. James F. Balch**, of Indianapolis, was elected a member of the Board of Trustees.

Ray E. Smith, executive secretary of the Indiana State Medical Association, has been elected president of the Indiana Health Council, an organization composed of agencies engaged in state health activities.

Announcement of the appointment of an outstanding medical writer to the position of editor of the American Academy of General Practice's forthcoming journal was made recently by the Publication Committee. He is **F. Kenneth Albrecht, M.D.**, formerly medical editor for Williams and Wilkins Company, medical book publishers of Baltimore, Maryland. **Arthur N. Jay, M.D.**, of Indianapolis, is a member of the Publication Committee.

The annual meeting of the **American Board of Obstetrics & Gynecology, Inc.**, was held in Chicago, Illinois, from May 8 to 14, 1949, at which time 236 candidates were certified.

New Bulletins, incorporating changes made at the recent meeting, are now available for distribution upon application and give details of all new regulations.

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on Friday, February 3, 1950. Application may be made until November 5, 1949. Application forms and Bulletins are sent upon request made to American Board of Obstetrics & Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Diagnosis and Treatment of Malignant Tumors will be the theme of the 35th annual meeting of the **Radiological Society of North America**.

The convention, scheduled for December 4 to 9, 1949, will be held in Cleveland with headquarters at the Public Auditorium and the Statler Hotel.

Carefully planned refresher courses, and scientific and commercial exhibits are included in the overall plan. Special emphasis is being placed on large-scale exhibits.

Advance registrations and hotel reservations are now being received for the 1949 Clinical Session—the third annual midyear meeting of the A.M.A.—to be held in Washington, December 6-9.

Attention to those details at this time will assure physicians a wide choice of hotel accommodations and will eliminate all delay in registering at the National Guard Armory upon arrival in Washington. Requests for reservations should be made before November 9 and sent to the Chairman of the Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, Star Building, Washington 4, D. C.

The Clinical Session will provide a full-scale scientific program specifically designed for the general practitioner. Outstanding physicians will discuss such subjects as diabetes, pediatrics, laboratory diagnosis, physical medicine and rehabilitation, arthritis, dermatology, x-ray diagnosis, cancer, poliomyelitis and other topics.

Coordinated with this outstanding scientific program will be approximately 100 scientific exhibits which will present original work on the subjects discussed.

Televised surgical and clinical procedures, similar to those shown in color at the A.M.A. annual session in Atlantic City last June, will be presented at the Washington meeting. The demonstrations will originate in the Johns Hopkins Hospital and will be shown on screens in the armory. The television schedule will be spread over four days.

For the convenience of doctors making advance registration and reservations, **The Journal of the American Medical Association** is publishing in its advertising section every week, convenient hotel reservation and advance registration blanks. Listed also are the leading hotels and their rates.

Miss Fern A. Goulding, R.N., has been recently employed by the Indianapolis Public Schools as Director of their School of Practical Nursing which is to be opened in the near future. Miss Goulding received her R.N. degree from the University of Michigan. During the past two years she has organized and directed the activities of the program of practical nurse education in the Detroit Public Schools.

Announcement has been made by **Dr. H. Roland Schroeder, Jr.**, of the opening of an office in Washington for the practice of obstetrics, gynecology and pediatrics. He is a graduate of the University of Louisville School of Medicine in 1946, and he spent a fifteen months' rotating internship at Indianapolis General Hospital. Following this, he entered the armed forces, where he served at Fort Knox and in the Arctic region.

Dr. James A. Alford has opened an office for the practice of medicine in Pleasant Lake. He also maintains an office in Hamilton.

Dr. Chester A. Stayton, of Indianapolis, was recently renamed chairman of the Executive Committee of the Indiana Cancer Society. Chairmen of standing committees for the coming year include: **Dr. Thurman B. Rice**, of Indianapolis, education; **Dr. Lall Montgomery**, Muncie, research; **Dr. Don D. Bowers**, of Indianapolis, professional education; and **Dr. Stayton**, special by-laws recodification. **Dr. Thurman B. Rice** was presented with a medallion by the national society, in recognition of outstanding service.

A 1945 graduate of Indiana University School of Medicine, **Dr. Fred Carter** has opened an office for the practice of medicine in Huntington. Doctor Carter interned at Indiana University Medical Center, and served in the United States Army's transportation corps on sea duty during World War II. For the past year Doctor Carter has been doing internal medical work at the Caylor-Nickel Clinic, in Bluffton.

Announcement was made recently by **Dr. W. Lawrence Daves** that **Dr. William D. Ritchie** is associated with him in the practice of medicine and surgery at 608 Old National Bank Building, in Evansville.

Dr. Ira L. Faith, of Boonville, has taken over the office vacated by **Dr. R. E. Zwickel**, at Newburg. Doctor Zwickel is taking postgraduate work.

Dr. John E. Fisher has announced the opening of an office for the practice of internal medicine at 409 Burr Building, in New Castle. He is a graduate of the University of Pennsylvania Medical School, and served his internship at Passavant Memorial Hospital, in Chicago. Doctor Fisher served for twenty-seven months in the Army during World War II, with the 97th Field Hospital in Hawaii. Since his discharge he completed residency training at Indianapolis General and Veterans Hospitals.

A 1946 graduate of the University of Louisville, **Dr. Don R. Hutchison** has begun the practice of medicine in Fountain City. He completed a fifteen-month internship at the Methodist Hospital in Indianapolis, before joining the armed forces, where he served on the staff at Fort Benning, Georgia.

Dr. Russell Lamb, of Indianapolis, presented a paper on "The Treatment of Varicose Veins and a Review of 1,000 Consecutive Saphenous Vein Operations," before the 26th annual meeting of the Association of Surgeons of the New York Central Railroad System in New York City, September 26.

Major Theodore S. Malinowski, of the Army Medical Corps, has been named to the staff of the Indiana University School of Medicine, as assistant professor of military science and tactics. He will also serve as a resident in internal medicine on the staff of the University Hospitals.

Dr. Walter Lee Owens, of Norman, has been appointed a physician in the Indiana University Student Health Service. A 1947 graduate of the Indiana University School of Medicine, Doctor Owens has been a member of the Student Health Service at Kansas State College.

Dr. George F. Parker has announced the opening of an office for the practice of pediatrics at 1517 N. Emerson Avenue, in Indianapolis. He graduated from the University of Cincinnati in 1944, and took postgraduate work in pediatrics at Cincinnati General Hospital, and at Gallinger Municipal Hospital, at Washington, D. C. He is a veteran of World War II.

A former Indianapolis physician, **Dr. James T. Pebworth**, has been appointed superintendent of the General Hospital at Silver City, New Mexico.

A former Illinois physician, **Dr. Elwood B. Phipps**, has announced the opening of an office for the practice of medicine in Clinton. He is a graduate of the University of Illinois and a veteran of World War II, having served with the Army Medical Corps in England.

Dr. Philip F. D. Seitz, formerly of the University of Pennsylvania staff, has been appointed assistant professor of psychiatry, and director of psychiatric research at Indiana University School of Medicine. Doctor Seitz is a native of Evansville, and the son of **Dr. Charles L. Seitz**. He is a graduate of the University of Pennsylvania school of medicine, and following his internship and residency at St. Louis City Hospital, he became chief of neuropsychiatry with the 280th General Hospital, and later chief of medicine with the 319th Station Hospital, both in Germany. Following his military service, Doctor Seitz went to the University of Pennsylvania as a teaching fellow in psychiatry, dermatology and syphilology. For the past year he has served as psychiatrist at the Skin and Cancer Hospital, in Philadelphia.

Dr. Ralph O. Smith has opened an office in Vincennes for the practice of internal medicine. A 1943 graduate of the University of Chicago, he served his internship and residency in internal medicine at Barnes Hospital and Washington University, in St. Louis. Following this, he served for two years in the medical corps of the armed forces, with the 391st station hospital in Italy, as chief of the medical service.

Deaths

John Francis Kerr, M.D., former Indianapolis physician, died on August 31 at Ft. Lauderdale, Florida, after a short illness. He was seventy-eight years of age. He graduated from the Medical College of Indiana, in Indianapolis, in 1902, and had practiced in Indianapolis for forty years. He moved to Ft. Lauderdale three years ago.

Norman W. Heysett, M.D., former Indianapolis physician, died on September 6 at the Irene Byron Sanatorium, in Fort Wayne, at the age of forty-five. He was a graduate of the Indiana University School of Medicine in 1929, and was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John August Salb, M.D., of Indianapolis, died on August 18, at the age of sixty-four. He was a graduate of the Indiana Medical College, School of Medicine of Purdue University, in Indianapolis, in 1907. He was a veteran of World War I, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Thomas Little Sullivan, M.D., an Indianapolis physician for forty years, died on September 6, at the age of sixty-three. Doctor Sullivan graduated from the Indiana University School of Medicine in 1920, and served for two years as superintendent of Indianapolis City Hospital, until he resigned to enter World War I. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association, and the American Medical Association.

Freeman R. Bannon, M.D., retired physician of Kokomo, died suddenly in Rochester, Minnesota, on September 28. He was sixty-two years of age. He graduated from the Indiana University School of Medicine in 1911, and began the practice of medicine in Kokomo shortly thereafter, where he continued to practice until his retirement, fifteen years ago. He was a veteran of World War I.

Orval E. Glick, M.D., of Kentland, died on August 25, after a long illness, at the age of seventy-five. He was a graduate of the Hahnemann Medical College, of Chicago, in 1901, and had practiced for forty-eight years. He began practice in Metcalf, Illinois, but came to Kentland in 1915 and had practiced there ever since. He was a member of the Jasper-Newton County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

James T. Hazel, M.D., retired physician of Freedom, died on September 18, at the age of eighty, after an illness of several years. Doctor Hazel was a graduate of the Hospital College of Medicine, Louisville, in 1900, and was an honorary member of the Owen-Monroe County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association. During World War I he served as a captain in the Army Medical Corps.

Paul T. Hurt, M.D., of Indianapolis, died suddenly on September 23 in Gadsden, Alabama, while en route to Florida. He was sixty-two years of age. He was a graduate of Indiana University School of Medicine in 1913, and had practiced in Indianapolis since that time. During World War I he served as a captain in the medical detachment of the 42nd Division. Doctor Hurt was a member of the Indianapolis Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Adam B. Knapp, M.D., of Vincennes, died on September 8, at the home of his son, Dr. Howard C. Knapp, in Belleville, Illinois. He was eighty-seven years of age. Following his graduation from the University of Tennessee College of Medicine, in Memphis, in 1891, he practiced in Worthington, Washington and Vincennes. He had practiced for more than fifty years, and was an Honorary member of the Knox County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

(Indianapolis Session, 1949)

First Meeting

The first meeting of the Council was held in the Kneipe Room of the Murat Temple, at 10:00 a.m., Monday, September 26, 1949, with Dr. Alfred Ellison, the chairman, presiding.

Roll call showed the following members present:

Councillors:

First District-----Herman T. Combs, Evansville
Second District-----William C. Reed, Bloomington
Third District-----William H. Garner, New Albany
Fourth District-----George A. May, Madison
Fifth District-----A. M. Mitchell, Terre Haute
Sixth District-----W. U. Kennedy, New Castle
Seventh District-----Cyrus J. Clark, Indianapolis
Eighth District-----E. H. Clauser, Muncie
Ninth District-----Wemple Dodds, Crawfordsville
Tenth District-----William H. Howard, Hammond
Eleventh District-----Elton R. Clarke, Kokomo
Twelfth District-----Paul A. Garber, South Whitley
Thirteenth District-----Alfred Ellison, South Bend

Councilor-elect:

Twelfth District-----M. B. Catlett, Fort Wayne

Officers:

Claude S. Black, Warren, president-elect.
N. K. Forster, Pacific Palisades, California, president
1945.
A. F. Weyerbacher, Indianapolis, treasurer.
Frank B. Ramsey, Indianapolis, editor of *THE JOURNAL*.
A. W. Cavins, Terre Haute, associate editor of *THE JOURNAL*.

Members of Executive Committee:

C. H. McCaskey, Indianapolis, chairman.
W. L. Portteus, Franklin.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, executive secretary.
James A. Waggener, field secretary.

Centennial Arrangements Committee:

J. Neill Garber, Indianapolis, chairman.

Legislative Committee:

J. William Wright, Indianapolis and
Donald E. Wood, Indianapolis, co-chairmen.

Indiana A.M.A. Campaign Coordinating Committee:

Cleon A. Nafe, Indianapolis, chairman.

On motion of Drs. Garber and Combs the minutes of the July 31, 1949, meeting of the Council, held in Indianapolis, were approved as printed in the September, 1949, *JOURNAL*.

District Meetings. The chairman asked that an effort be made to avoid conflicts in district meeting dates by clearing the dates somewhat in advance of the meetings with the headquarters office.

Unfinished Business

1. *Convention arrangements.* Dr. J. Neill Garber reported that everything was in readiness for the centennial session and that advance reservations for the various events indicated that the meeting would be well attended.

2. *Mutual Medical Insurance, Inc.* Dr. Kennedy, president: "The insurance company is making excellent progress with a fairly satisfactory membership increase, both in membership and in reserves. The Blue Cross has doubled its selling force, and we have every reason to expect a still greater rate of increase in our coverage.

"We have long realized the need of a wider coverage, particularly in purely medical matters. In order that we may adequately supply the necessary demands of the public, statistics are presently available to give us a clear-cut, sound knowledge of the costs of such coverage. It will be necessary for us to make controlled experiments before jumping into a complete program. This we have long known, and now are studying. Our first venture is the selling of individual certificates outside of organized groups to meet a quite pressing demand. These certificates will be available within the month, and blank applications will be sent out to every doctor in the state, for distribution. After that, other means will be found for still wider distribution, and after an experience of some months we will know how much farther and how much wider and at what costs.

"We recognize a single goal, that of complete coverage, and without the attainment of that goal all of our efforts will be washed out.

"Politically, all is serene on the surface at this time, but we are warned by those who know best that we must not lessen our continuous efforts but keep up a constant campaign against compulsory medical care though the intensity of that campaign ought to be modified from time to time."

3. *Committee on Medical Education and Hospitals.*

Dr. Clauser, chairman, reported that at a meeting on August 28 his committee decided that it had no recommendations other than those made in its report which was printed in the September issue of *THE JOURNAL* and in the House of Delegates Handbook. "It was felt, however," Dr. Clauser said, "that during the coming year substantial progress can be expected in the program of postgraduate courses. We feel that our field secretary will have more time to devote to this work. Further, after exhaustive discussion, it was agreed that the matter of recommendations regarding opportunities for postgraduate training of foreign students be tabled at this time. The committee strongly feels, however, that Indiana facilities for graduate training should be extended to foreign students as well as to domestic students as rapidly as possible."

New Business

1. *Legislative matters.* Dr. Wright, co-chairman of the Committee on Public Policy and Legislation, spoke briefly on the current and contemplated activities of his committee.

2. *Executive Committee matters.* Dr. McCaskey, chairman, presented the following matters:

a. *Recommendation regarding rebating.* At the request of the Executive Committee, on motion of Drs. C. J. Clark and Mitchell, the Council rescinded the action taken at its July 31, 1949, meeting in which it approved the recommendation contained in the report of the A.M.A. Committee on Rebates. This report, which was presented at the interim session in St. Louis in December, 1948, reads as follows: "The committee urges that the different state societies in those states in which such practices are not now illegal give serious consideration to the introduction of legislation making the practice of rebating to or by physicians illegal."

b. *Check signatures.* On motion of Drs. C. J. Clark and Garber, the Council approved the suggestion of the Executive Committee that the recommendation be made to the House of Delegates that the By-laws be changed so that two signatures instead of three would be required on association checks.

c. *Training of technicians for physicians' offices.* The officers of the Indiana Academy of General Practice presented to the Executive Committee a resolution regarding the establishment of a short training course for technicians who work in physicians' offices. The Executive Committee, on motion of Drs. Black and Portteus, recommended that further study be given to this problem before any definite action is taken, that a report on the study be made at the spring meeting of the Council, and that this study be carried on by the following personnel:

1. Two members to be appointed from the Indiana State Medical Association.
2. Two members to be appointed by the Indiana Academy of General Practice.
3. Two members from the Indiana Association of Pathologists.
4. Two representatives from the Indiana University School of Medicine, to be selected by the dean of the Medical School.

On motion of Drs. Mitchell and Dodds, the Council concurred in this recommendation.

3. *Nominations for General Practitioner of the Year Award.* The special committee of the Council reported that it had reviewed not only the nominations which had been presented this year, but also those of 1948. Of the twenty-one nominations for this award, on recommendation of the committee, and on motion of Drs. C. J. Clark and Combs, the following three names were to be presented to the House of Delegates:

Charles C. Crampton, Delphi
Walter F. Kelly, Indianapolis
David D. Todd, Elkhart

4. *Election of JOURNAL editors.* On motion of Drs. Mitchell and Garber, Dr. Frank B. Ramsey, Indianapolis, was re-elected editor of THE JOURNAL for 1950, and Dr. A. W. Cavins, Terre Haute, was re-elected associate editor of THE JOURNAL for 1950.

5. *Election of Editorial Board Members.* Dr. Wemple Dodds, Crawfordsville, and Dr. Stephen L. Johnson, Evansville, were elected members of the Editorial Board to serve for three years and to succeed Dr. Lall Montgomery, Muncie, and Dr. Pierce MacKenzie, Evansville.

6. *Indiana A.M.A. Campaign Coordinating Committee.* Dr. Nafe, chairman, told of the plans of his committee for a radio and newspaper advertising campaign to combat compulsory health insurance, if such a proposal is approved by the Council and the House of Delegates. The cost would be as much as \$95,000 to \$100,000 per year, depending on the number of radio announcements made and the amount of newspaper advertising done. Mr. Waggener, field secretary, outlined the plan in detail. (See supplemental report of Indiana A.M.A. Campaign Coordinating Committee to the House of Delegates, pages 1179 and 1180.)

Following discussion by Drs. C. J. Clark, Portteus, Howard, Dodds and Ellison, on motion of Drs. Mitchell and Combs, the Council voted to recommend to the House of Delegates an increase in state association membership dues of \$20.00, which would make the state dues \$35.00 per year, beginning in 1950.

Plea for Medical Officers for Summer Field Training Camp

Robinson Hitchcock, Adjutant General of Indiana, appeared before the Council to tell of the shortage of and urgent need for medical officers for summer training camp. "With 6,000 men in camp, in one 24-hour period at Fort Knox this summer there was not a single medical officer on the base. . . . We would like to know if

any member of your Council has some recommendation to make whereby we might have some members of the medical profession attend our field training camp. They will build up their reserve points so that when they retire they will get a little more compensation. I hope you will give this consideration whereby somebody can confer with our office relative to the problem."

In answer to the question, "What would be expected of doctors who did join up with this movement?", General Hitchcock said, "They would be required to spend two weeks in camp, generally the first two weeks in August, and they would be expected to drill or meet with their group for two hours one evening a week. They would be commissioned officers in the Indiana National Guard."

Dr. C. J. Clark suggested that General Hitchcock talk with the Committee on Veterans Affairs of the association regarding this matter. No further action was taken by the Council.

Date for Midwinter Council Meeting

The Council set Sunday, January 15, 1950, as the date for the midwinter meeting.

There being no further business, the Council adjourned at 2:00 p.m., to meet again on Thursday, September 29, immediately following adjournment of the House of Delegates.

THE COUNCIL

(Indianapolis Session, 1949)

Second Meeting

The second meeting of the Council convened immediately following adjournment of the House of Delegates, Thursday afternoon, September 29, 1949, in the Auditorium of the Athenaeum, with Dr. Alfred Ellison, the chairman, presiding:

Roll call showed the following members present:

Councillors:

First District-----Herman T. Combs, Evansville
Second District-----William C. Reed, Bloomington
Third District-----William H. Garner, New Albany
Fourth District-----George A. May, Madison
Fifth District-----A. M. Mitchell, Terre Haute
Sixth District-----W. U. Kennedy, New Castle
Seventh District-----Cyrus J. Clark, Indianapolis
Eighth District-----Not represented
Ninth District-----Wemple Dodds, Crawfordsville
Tenth District-----William H. Howard, Hammond
Eleventh District-----Elton R. Clarke, Kokomo
Twelfth District-----M. B. Catlett, Fort Wayne
Thirteenth District-----Alfred Ellison, South Bend

Officers:

Augustus P. Hauss, New Albany, president.
Claude S. Black, Warren, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.

Members of Executive Committee:

C. H. McCaskey, Indianapolis, chairman.
W. L. Portteus, Franklin.

Delegate to A.M.A.:

William M. Cockrum, Evansville.

Dr. Cockrum read the following resolution which was approved by the Council on the motion of Drs. C. J. Clark and Dodds:

WHEREAS, there have been several complaints received that holders of pre-paid insurance plans are, in numerous instances, being diverted by large employers to their company doctors instead of their family doctors, and

WHEREAS, the A.M.A. and its constituents stoutly defend the right of the individual to free choice of physician, and

WHEREAS, should diversion tactics of such policy-holders become widespread, it might result in regimentation of doctors by insurance companies,

Therefore, Be It Resolved, That the House of Delegates of the American Medical Association recommend to the various insurance companies and plans that they incorporate on their policies in bold print the following legend:

"This Policy guarantees to the holder his free choice of physician or surgeon."

Additional Appropriation for Committee on Diabetes. At the request of Dr. M. I. Hewitt, chairman of the Committee on Diabetes, who appeared before the Council, and on the motion of Drs. Howard and C. J. Clark, the Council voted \$100.00 additional appropriation to the Committee on Diabetes for 1949, to meet current expenses of the committee.

Election of Chairman of Council

Dr. W. U. Kennedy was elected chairman of the Council to succeed Dr. Alfred Ellison, who resigned because of his election as president-elect for 1950.

No further business appearing, the Council adjourned.

HOUSE OF DELEGATES

(Indianapolis Session, 1949)

First Meeting

The House of Delegates convened in the Murat Theater at 3:25 p.m., Monday, September 26, 1949, with the president-elect, Dr. Claude S. Black, of Warren, presiding.

Dr. George R. Daniels' motion that the attendance slips, signed by the delegates, constitute the roll call was seconded by several, and carried. These slips showed the following members present:

County	Delegates
Adams-----	Ben Duke, Decatur
Allen-----	Maurice E. Glock, Fort Wayne Arthur J. Roser, Fort Wayne Elmer C. Singer, Fort Wayne
Bartholomew-	
Brown-----	Lowell F. Beggs, Columbus Kenneth D. Schneider, Nashville
Benton-----	V. L. Turley, Fowler
Boone-----	Jack Porter, Lebanon
Carroll-----	Hubert Gros, Delphi
Cass-----	E. B. Jewell, Logansport
Clark-----	E. P. Buckley, Jeffersonville
Clay-----	Robert K. Webster, Brazil
Clinton-----	F. A. Beardsley, Frankfort
Dearborn-Ohio----	Charles N. Manley, Rising Sun
Decatur-----	J. M. Pfeifer, Lawrenceburg D. D. Dickson, Greensburg
Delaware-	
Blackford-----	William T. Douglas, Montpelier O. A. Hall, Muncie G. S. Young, Muncie
Dubois-----	Charles H. Klamer, Jasper
Elkhart-----	Sam T. Miller, Elkhart A. C. Yoder, Goshen
Fayette-Franklin----	Frank H. Neukamp, Connersville
Floyd-----	John M. Paris, New Albany
Fountain-Warren----	James W. Crain, Williamsport Lee J. Maris, Attica
Fulton-----	A. E. Stinson, Rochester
Gibson-----	Virgil McCarty, Princeton
Grant-----	Russell Lavengood, Marion
Hancock-----	Robert O. Scott, Charlottesville
Harrison-----	William E. Amy, Corydon
Hendricks-----	O. T. Scamahorn, Pittsboro
Henry-----	L. C. Marshall, Mt. Summit
Howard-----	Richard P. Good, Kokomo
Huntington-----	Howard H. Marks, Huntington

County	Delegates
Jackson-----	Harold E. Miller, Seymour
Jasper-Newton-----	Frank G. Sink, Remington
Jay-----	George V. Cring, Portland
Jefferson-----	S. A. Whitsitt, Madison
Johnson-----	O. A. Province, Franklin
Knox-----	Virgil C. McMahan, Vincennes
LaGrange-----	K. M. Lehman, Topeka
Lake-----	J. Robert Doty, Gary H. W. Eggers, Hammond Samuel J. Petronella, East Chicago Michael Shellhouse, Gary H. R. Stimson, Gary
Lawrence-----	Claude Dollens, Oolitic
Madison-----	C. V. Rozelle, Anderson G. B. Wilder, Anderson
Marion-----	R. M. Dearmin, Indianapolis Murray DeArmond, Indianapolis James W. Denny, Indianapolis Bert E. Ellis, Indianapolis Robert D. Howell, Indianapolis Harold C. Ochsner, Indianapolis Frank B. Ramsey, Indianapolis O. W. Sicks, Indianapolis Sydney L. Stevens, Indianapolis J. M. Whitehead, Indianapolis Wm. N. Wishard, Jr., Indianapolis J. William Wright, Indianapolis
Marshall-----	A. A. Thompson, Tyner
Miami-----	Stephen D. Malouf, Peru
Montgomery-----	James M. Kirtley, Crawfordsville
Morgan-----	Edward M. Pitkin, Martinsville
Noble-----	J. R. Nash, Albion
Owen-Monroe-----	William A. Karsell, Bloomington Frederick A. Smith, Spencer
Pike-----	Milton H. Omstead, Petersburg
Posey-----	William B. Challman, Mt. Vernon
Putnam-----	James B. Johnson, Greencastle
Randolph-----	J. S. Robison, Winchester
Rush-----	Melvin H. Denny, Rushville
St. Joseph-----	E. Blackburn, South Bend F. R. Nicholas Carter, South Bend A. S. Giordano, South Bend Marshall I. Hewitt, South Bend Floyd S. Napper, Scottsburg
Scott-----	W. D. Inlow, Shelbyville
Shelby-----	Guy B. Ingwell, Knox
Starke-----	C. F. Briggs, Sullivan
Sullivan-----	L. H. Bear, Vevay
Switzerland-----	Raymond R. Calvert, Lafayette Gordon A. Thomas, Lafayette
Tippecanoe-----	Paul D. Crimm, Evansville Minor Miller, Evansville
Vanderburgh-----	Ernest O. Nay, Terre Haute M. C. Topping, Terre Haute G. W. Seward, North Manchester
Vigo-----	Irvin E. Huckleberry, Salem
Wabash-----	Will A. Thompson, Liberty
Washington-----	Harry Plummer Ross, Richmond
Wayne-Union-----	Allen C. Nickel, Bluffton
Wells-----	B. F. Pence, Columbia City
Whitley-----	

Councillors

- 1st District—Herman T. Combs, Evansville
- 2nd District—William C. Reed, Bloomington
- 3rd District—William H. Garner, New Albany
- 4th District—George A. May, Madison
- 5th District—A. M. Mitchell, Terre Haute
- 6th District—W. U. Kennedy, New Castle
- 7th District—C. J. Clark, Indianapolis
- 8th District—E. H. Clauser, Muncie
- 9th District—W. Dods, Crawfordsville
- 10th District—W. H. Howard, Hammond
- 11th District—Elton R. Clarke, Kokomo
- 12th District—Paul A. Garber, South Whitley
- 13th District—Alfred Ellison, South Bend

Past Presidents

Charles N. Combs, Terre Haute
 George R. Daniels, Marion
 F. S. Crockett, Lafayette
 Herman M. Baker, Evansville
 Carl H. McCaskey, Indianapolis
 J. T. Oliphant, Farmersburg
 N. K. Forster, Pacific Palisades, Calif.
 J. E. Ferrell, Fortville
 Cleon A. Nafe, Indianapolis

Officers

Claude S. Black, Warren, president-elect
 A. F. Weyerbacher, Indianapolis, treasurer
 Albert Stump, attorney for association
 Ray E. Smith, executive secretary
 James A. Waggener, field secretary

Delegates to A.M.A.

William M. Cockrum, Evansville
 Homer G. Hamer, Indianapolis

Dr. William E. Amv, chairman of the Reference Committee on Credentials, announced that 95 delegates, 13 councilors, and 9 past presidents were present.

THE CHAIRMAN: That constitutes a quorum, and we shall proceed with our business.

At this time I want to call attention to the fact that we have Dr. N. K. Forster with us. He has served this association faithfully and well and he has come to this meeting from the State of California, where he now resides, to be here at this centennial celebration. (Applause.)

In Memoriam

THE CHAIRMAN: We will stand for one minute in silent tribute to the memory of those who were members of the House of Delegates, or who served the state association in an official capacity, who have died since the 1948 session. I will first read their names and locations:

WALTER H. BAKER, South Bend. Secretary St. Joseph County Medical Society, 1914. Member of Committee on Physicians' Welfare, 1914-1915; Committee on Graduate Education, 1934 and 1935; and Committee for the Study of Lay Activity in Medical Practice, 1944.

NORMAN M. BEATTY, Indianapolis. Chairman of the Committee on Public Policy and Legislation, 1937 and 1938; co-chairman of the Committee on Public Policy and Legislation, 1939 to December, 1948; chairman of Committee on Arrangements, 1938; member of Committee on Indiana Inter-Professional Health Council, 1938 to December, 1948; member of Committee on Convention Arrangements, 1941; member of Council on Medical Service and Public Relations, 1945 and 1946; member of Committee on Medical and Nursing School Scholarships, 1947 and 1948; alternate delegate to the American Medical Association, 1938 to December, 1948; delegate from Marion County, 1945.

E. G. BLINKS, Michigan City. Member of Committee on Credentials, 1911-1912.

ETTA CHARLES, Anderson. Secretary Madison County Medical Society, 1910 through 1914.

W. B. CHRISTOPHEL, Mishawaka. Councilor of Thirteenth District, 1933 through 1938.

L. L. EBERHART, Angola. Delegate from Steuben County, 1937.

B. W. EGAN, Logansport. Chairman, Section on Ophthalmology and Otolaryngology, 1939 and 1940; delegate from Cass County, 1936, 1937, 1938, 1940 through 1944.

HARRY G. ERWIN, LaGrange. Delegate from LaGrange County, 1938, 1940, 1941.

ALBERT FISHER, North Judson. Delegate from Starke County, 1937 and 1938.

LOWELL M. GREEN, Rushville. Secretary Rush County Medical Society, 1908 through 1917; member Committee on Industrial Health, 1940; and Committee on Venereal Disease, 1942, 1943 and 1944.

H. H. KAMMAN, Columbus. Secretary Bartholomew County Medical Society, 1919 and 1920.

SAMUEL KENNEDY, Shelbyville. Councilor Sixth District, 1932 through 1944.

A. J. LAUER, Whiting. Member Committee on Civic and Industrial Relations, 1933, 1934 and 1935, and Committee to Study Cultists and Irregular Practitioners, 1938, 1939 and 1940.

CARLETON B. McCULLOCH, Indianapolis. Member M-Day and Veterans' Affairs Committee, 1941 and 1942; member War Participation Committee, 1943, 1944 and 1945; and Postwar Committee, 1946.

A. L. MARSHALL, Indianapolis. Member Committee on Public Policy and Legislation, 1917, 1918, 1924 and 1925; secretary Indianapolis Medical Society, 1918 and 1919; chairman of Committee on Credentials, 1921 and 1922; member Committee on Arrangements, 1924; member Committee on Administration and Medical Defense, 1925 and 1926; member Executive Committee, 1927 and 1928.

B. W. RHAMY, Fort Wayne. Member of Committee on Pathology, 1911-1913; Committee on Scientific Demonstrations, 1914-1915; chairman of Committee on Scientific Exhibit, 1916; and member of Committee on Scientific Exhibit, 1949; member Committee on Control of Syphilis, 1938 through 1943; member Committee on Venereal Disease, 1944.

L. L. SHULER, Indianapolis. Member of Liaison Committee with Indiana Crippled Children's Bureau, 1940, 1941 and 1942; delegate from Marion County, 1937, 1939, 1940 and 1941.

JOSEPH C. SILVERS, Muncie. Member Permanent Study Committee on Health Insurance, 1941.

MARTIN B. STRANGE, New Albany. Member Committee on Heart Disease, 1949.

J. C. WALLACE, Fort Wayne. Secretary, Allen County Medical Society, 1909 and 1910.

JAMES Y. WELBORN, Evansville. Member Committee on Tuberculosis, 1911-1912; Councilor First District 1918-1920; delegate from Vanderburgh County, 1944.

E. K. WESTHAFFER, New Castle. Secretary Henry County Medical Society, 1908.

(On motion of Drs. Daniels and A. M. Mitchell, the minutes of the previous meetings, as published in *THE JOURNAL* were approved.)

The chairman announced that Article V of the Constitution gives the A.M.A. delegates the right to sit in the House of Delegates, with the privilege of the floor, but with no power to vote. He also extended an invitation to all members of the association to sit in this meeting of the House.

1949 Reference Committees

THE CHAIRMAN: I shall read the names of the members of the reference committees and ask that the members of each of these committees please stand when their names are read.

1. Sections and Section Work:

Chairman, Ernest P. Buckley, Jeffersonville (Clark)

Vice-Chairman, R. R. Calvert, Lafayette (Tippecanoe)

Keith Hammond, Paoli (Orange)

E. M. Pitkin, Martinsville (Morgan)

A. C. Nickel, Bluffton (Wells)

2. Rules and Order of Business:

Chairman, Frank B. Ramsey, Indianapolis (Marion)
 Vice-Chairman, Elton R. Clarke, Kokomo (Howard)
 N. K. Forster, Pacific Palisades, California (Lake)
 James W. Denny, Indianapolis (Marion)
 M. C. Topping, Terre Haute (Vigo)

3. Medical Education and Hospitals:

Chairman, C. H. McCaskey, Indianapolis (Marion)
 Vice-Chairman, C. J. Clark, Indianapolis (Marion)
 I. E. Huckleberry, Salem (Washington)
 Murray DeArmond, Indianapolis (Marion)
 Elmer Singer, Fort Wayne (Allen)

4. Public Policy and Legislation:

Chairman, F. R. N. Carter, South Bend (St. Joseph)
 Vice-Chairman, John M. Paris, New Albany (Floyd)
 E. H. Clauser, Muncie (Delaware-Blackford)
 George V. Cring, Portland (Jay)
 V. L. Turley, Fowler (Benton)

5. Publicity:

Chairman, William N. Wishard, Jr., Indianapolis (Marion)
 Vice-Chairman, Gordon A. Thomas, Lafayette (Tippecanoe)
 Will A. Thompson, Liberty (Wayne-Union)
 Wemple Dodds, Crawfordsville (Montgomery)
 Herman T. Combs, Evansville (Vanderburgh)

6. Hygiene and Public Health:

Chairman, Harry P. Ross, Richmond (Wayne-Union)
 Vice-Chairman, Minor Miller, Evansville (Vanderburgh)
 M. I. Hewitt, South Bend (St. Joseph)
 George A. May, Madison (Jefferson)
 William A. Karsell, Bloomington (Owen-Monroe)

7. Amendments to Constitution and By-Laws:

Chairman, Paul D. Crimm, Evansville (Vanderburgh)
 Vice-Chairman, Cleon A. Nafe, Indianapolis (Marion)
 A. M. Mitchell, Terre Haute (Vigo)
 F. S. Crockett, Lafayette (Tippecanoe)
 J. E. Ferrell, Fortville (Hancock)

8. Reports of Officers:

Chairman, Virgil McCarty, Princeton (Gibson)
 Vice-Chairman, Alfred Ellison, South Bend (St. Joseph)
 Melvin H. Denny, Rushville (Rush)
 Bert Ellis, Indianapolis (Marion)
 William C. Reed, Bloomington (Owen-Monroe)

9. Committee On Credentials:

Chairman, William E. Amy, Corydon (Harrison)
 Vice-Chairman, Claude Dollens, Oolitic (Lawrence)
 J. R. Doty, Gary (Lake)
 Howard H. Marks, Huntington (Huntington)
 O. T. Scamahorn, Pittsboro (Hendricks)

10. Committee On Miscellaneous Business.

Chairman, J. William Wright, Indianapolis (Marion)
 Vice-Chairman, William H. Garner, New Albany (Floyd)
 W. U. Kennedy, New Castle (Henry)
 C. V. Rozelle, Anderson (Madison)
 A. C. Yoder, Goshen (Elkhart)

All reports and resolutions presented to the House today will be referred to these reference committees and the recommendations of these committees shall be submitted to the House at its last meeting on Thursday. Time will be given at the conclusion of this meeting for the chairmen of each reference committee to announce on the floor of the House the time and place that his committee is to meet.

Reports of Officers

These reports, except the address of the president and the president-elect, are printed in the September JOURNAL and in the Handbook, but each officer will be allowed five minutes to make any additions to the reports already published.

The president's address, to be made before the general meeting on Tuesday, will be referred to the Reference Committee on Reports of Officers.

Address of President-elect

At this time Dr. Alfred Ellison took the chair while Dr. Black delivered the following address, which was referred to the Reference Committee on Reports of Officers:

DR. CLAUDE S. BLACK: Dr. Hauss, guests, delegates and members of the Indiana State Medical Association: I first want to thank you for placing your confidence in me in electing me president for 1950. With your assistance and cooperation, I hope we will have a successful year.

The great progress medicine has made during the past century gives us something to shoot at—many traditions to uphold and much able leadership to emulate. With these goals to spur us on to greater accomplishments, and, with your assistance, let us make a good start and set an example for the second century of the Indiana State Medical Association.

The medical profession is now being confronted by a compulsory prepaid medical care plan, championed by Federal Security Administrator Oscar Ewing and the President of the United States. They are using the argument that the American Medical Association is raising a slush fund of \$3,500,000. This is not a slush fund, as you know, but an educational fund to be used to inform the public of conditions which would prevail under the proposed plan. But Mr. Truman and Mr. Ewing neglect to tell you that they have spent many more millions than this to propagandize their own plan through using various bureaus and agencies which we taxpayers are supporting. The medical profession needs to stress the fact that medical care, under Mr. Truman's plan, will be paid for in two ways: by withholding personal income, and by increasing other taxation to make up the deficit. Because the existing political activity is harmful to our profession, I think we should all interest ourselves in politics. I don't necessarily mean partisan politics, but I mean we must, by constant vigilance, make sure that nobody is nominated on either party ticket, locally or nationally, who is not fair to the medical profession. I wish to quote the stand taken in regard to socialized medicine by Indiana's Senator Capehart, Senator Jenner and Congressman Walsh, who represents my own district. These letters are of recent date. They were requested by me for quotation to this society. I thought you should know their opinions.

I now read the letter received from Senator Capehart: "Why the nation with the greatest health standards in the world and a record of the greatest gain in medical science despite its comparative youthfulness among the world's great nations, should seek to turn to a foreign system of medical treatment is beyond me.

"That is not progression. It is retrogression.

"Socialized medicine could rightfully be classified as our greatest step toward a completely paternal government.

"With it we would destroy another freedom for both the patient and the physician.

"With it we would gain nothing.

"I received a letter the other day in support of socialized medicine—one of the few I have thus far received—expressing that opinion against the thousands I have received opposing socialized medicine.

"The writer of the letter favoring the socialization of medicine complained that she had not recovered from an ailment under the present system of treatment.

"That writer did not realize that socialized medicine will have no bearing on her possible recovery from treatment; unless it would be to reduce the possibility of recovery due to reduced efficiency in the world of medical science.

"I mention this as one of the misunderstandings of socialized medicine.

"America's record in health advancement in 170 years is a boast of the nation. Let's stand on that record."

The junior senator, Mr. Jenner, sent me the following statement:

"I am informed that approximately two thousand years were required to increase life expectancy from 25 to 45 years. Progress in the science of medicine, combined with the untiring effort of your forefathers and you in medicine, in the space of fifty years moved this age from 45 to a life expectancy of 65 years. However, in the past three years, this figure has risen six and one-half years until the expectancy is 71½ years.

"No greater tribute could be paid to the present system of medicine, and it would be folly to endanger that system.

"I am unalterably opposed to governmental interference or regulation of the methods of medical science. There are, however, many visionaries who are willing to scrap proved methods for social experimentation.

"While it is not expected the complete program of these medical stargazers will be carried to completion during this session of Congress, however there is grave danger what little part of that program can be accomplished might be the entering wedge for more complete action in the future.

"To say 'vigilance is the price of liberty' may be trite, but it is timely. Your tremendous influence with your own patients will be of inestimable value to your friends in the country's legislative halls.

"Public support of your program will give us the courage to carry on."

Congressman Walsh of the Fifth District expressed his views on socialized medicine as follows:

"When I came to Washington in January, I was opposed to Compulsory Health Insurance. My views have not completely changed on the subject, but I can say that I am not certain as to how I might vote in case the matter was presented at this time.

"As your Representative, I have received thousands of form letters, many of them were abusive and derogatory, and it has been reported that I favor socialized medicine, which is an outright falsehood, and the only statement I have ever made is that I favor careful consideration of the President's program, and I propose to keep an open mind on the subject until the Committee has completed its hearings and all the evidence is in.

"There is no likelihood that this bill will be presented to Congress this session, and I have asked to appear before the Committee of Physicians Opposed to Socialized Medicine, but due to conflicting dates and the physicians' vacations, they have been unable to meet with me, but I can assure you that before casting my vote, and before making up my mind on the subject, I will meet with their committee, as well as with many other groups both favoring and disfavoring the bill, then vote for what I consider to be for the welfare of the American People. I might say, Dr. Black, that pressure mail has no effect upon the Congressmen, and sometimes has just the opposite effect. I fear there was a time during the last few months when I might have voted for Compulsory Health Insurance, because of the type of opposition that was generating against the bill, but upon clear thinking I realized that this might have a negative effect on the people, and I am determined to make my decision on merit, and merit alone, and a few pressure groups will not affect my views, once they are arrived at.

"I do appreciate hearing from you and having your views on the subject of medical insurance."

To the best of my information, of the other ten Indiana Congressmen, seven are opposed to socialized medicine, the standing of two is questionable, and the other one is for it.

Our country is being so infiltrated with communistic and socialistic ideas that it behooves us all to stand for good government and good, clean standards of living; to stand for free speech, free religious beliefs, and the right to conduct our business according to the dictates of our own conscience. These are the things that have made America great. Let us keep it so! We must fight socialized medicine in order to maintain our freedom of personal relations with people.

I have chosen "Service" as my slogan for the coming year. By "Service" I mean service that is courteous, prompt, efficient, and at a price people can afford. And, I advocate that we create good public relations. We should form closer relations between physician and patient, closer relations to school groups, better cooperation with our good farm folks, better and closer relations with the press and radio groups, and a very close alliance between the medical profession and the Auxiliary. (This should be easy because we are married to them.) I consider the Auxiliary our most valuable public relations group. In churches, clubs, P.-T.A.'s sororities, and many other organizations, it has always been a woman who holds a lamp for a man's progress.

Within the latter half of this past century we are observing, as medical men, that the medical center of the world has moved from Europe to the United States. Our country has more doctors per capita than any other country—one doctor for every 706 people. The nearest approach to this is in England where there is a doctor for every 886 people. Distribution of doctors in the United States may be bad now, but time will eventually adjust that, for no doctor will remain where he can't make a living. The medical profession has answered the call for two recent wars, conducting itself with honor to the profession and to our country at probably a greater sacrifice than any other group of people. And now, in peacetime, for a peacetime army, Defense Secretary Johnson is demanding that more medical men volunteer for military service. Indiana's quota is 67. Let us lend our aid to this procurement and avoid the necessity of a medical draft.

I think we should commend the state of Indiana on the progress being made in its care of the mentally ill. The program was started under the able leadership of Doctor Beatty, and is being carried on by Doctor Porteus and his associates. The State Board of Health should be commended for its forward-looking program and its diligent battle against polio. This board, under the guidance of Dr. Jacob T. Oliphant as president, with Doctor Ross and Doctor Lavengood as members, works with Dr. L. E. Burney, Health Commissioner, and his able staff. And Dr. Frank Ramsey and Dr. A. W. Cavins should be commended for their fine JOURNAL.

I wish to call attention to the following items coming before the House of Delegates, and I solicit your approval:

1. An increase of \$20.00 in our annual dues, which will be greatly needed for public education, to combat legislation on socialized medicine, and to combat the more strenuous efforts of the chiropractors to get a separate board of their own.
2. To pay the annual Auxiliary dues with our own.
3. I recommend that all officers' terms should expire at the last day of each state convention, in order to expedite efficient operation of the Association.
4. That five ex-presidents should become a Grievance Committee, functioning to handle complaints and requests received from both the public and the medical profession.
5. That the two immediate past presidents of the association be made members of the councilor body in an advisory capacity.

I want to congratulate Doctor Hauss and his various committees for making this centennial year a great success. I want to congratulate, too, the Headquarters Office with Ray Smith at the helm, Dr. Neill Garber for his planning of the program, Dr. Thurman Rice for his wonderful exhibit depicting 100 years of medical practice in Indiana, Dr. Charles Combs and Dr. Edgar Kiser in compiling and writing for preservation *One Hundred Years of Indiana Medicine*, and Dr. William Wright and Dr. Don Wood for their wonderful work as co-chairmen of the legislative committee.

And now, may I ask each one of you for your assistance and cooperation during the coming year? I will need it.

Dr. Black resumed the chair and proceeded with the reports of officers, as follows:

Reports of the Executive Secretary, the Treasurer, the Chairman of the Council, and the councilors, all of which were referred to the Reference Committee on Reports of Officers.

Reports of Standing and Special Committees

THE CHAIRMAN: These reports are printed in the September issue of *THE JOURNAL* and in the Handbook, but each chairman will receive five minutes in which to make any additions to or explanation of the reports already published, if he so desires.

Executive Committee—Referred to Reference Committee on Reports of Officers.

Centennial Arrangements—Referred to Reference Committee on Miscellaneous Business.

Scientific Work—Referred to Reference Committee on Sections and Section Work.

Public Policy and Legislation—Dr. J. William Wright, co-chairman, introduced Dr. Walter F. Kelly, Indianapolis, a former member of the Legislative Committee, past president of the Indianapolis Medical Society, and senator from Marion county. Report referred to Reference Committee on Public Policy and Legislation.

Publicity—Referred to Reference Committee on Publicity.

Medical Education and Hospitals—Referred to Reference Committee on Medical Education and Hospitals.

Public Relations—Referred to Reference Committee on Public Policy and Legislation.

Auditing—Referred to Reference Committee on Reports of Officers.

Cancer—Referred to Reference Committee on Hygiene and Public Health.

Centennial History and Publications—Referred to Reference Committee on Publicity.

Civic Relationship and Community Health Agencies—Referred to Reference Committee on Miscellaneous Business.

Conference of County Medical Society Officers—Referred to Reference Committee on Miscellaneous Business.

Conservation of Vision—Referred to Reference Committee on Hygiene and Public Health.

Constitution and By-Laws—Referred to Reference Committee on Amendments to Constitution and By-Laws.

Crippled Children Services and Infantile Paralysis—Referred to Reference Committee on Public Policy and Legislation.

Diabetes—Referred to Reference Committee on Hygiene and Public Health.

Hard of Hearing—Referred to Reference Committee on Hygiene and Public Health.

Heart Disease—Referred to Reference Committee on Hygiene and Public Health.

Historical Exhibits—Referred to Reference Committee on Publicity.

A.M.A. Campaign Co-ordinating Committee—Referred to Reference Committee on Miscellaneous Business.

Indiana Inter-Professional Health Council—Referred to Reference Committee on Miscellaneous Business.

Indigent Medical Care—Referred to Reference Committee on Public Policy and Legislation.

Industrial Health—Referred to Reference Committee on Hygiene and Public Health.

Instructional Courses—Referred to Reference Committee on Sections and Section Work.

Maternal and Child Health—Referred to Reference Committee on Public Policy and Legislation.

Medical and Nursing School Scholarships—Referred to Reference Committee on Medical Education and Hospitals.

Mental Health—Referred to Reference Committee on Hygiene and Public Health.

Prepaid Medical and Hospital Insurance—Referred to Reference Committee on Miscellaneous Business.

Rural Health—Referred to Reference Committee on Public Policy and Legislation.

School Health and Physical Education—Referred to Reference Committee on Hygiene and Public Health.

Scientific Exhibit—Referred to Reference Committee on Sections and Section Work.

State Fair—Dr. Malcolm O. Scamahorn, chairman, presented the report of the committee as contained in the Handbook and the following supplementary report, which were referred to the Reference Committee on Publicity:

The Committee on State Fair has this additional report to make. Over 9,000 individuals had their blood pressure taken during the 1949 State Fair. Therefore, it is understandable that the A.M.A. exhibits on Trichinosis, Skin in Health and Disease, and Respiratory System in Health and Disease were well visited and provided good lay information. With the gratefully appreciated help of the Indianapolis Medical Society Auxiliary members, approximately 30,000 pieces of anti-compulsory health insurance literature were placed in the hands of the adult fair-goers visiting the exhibit.

Traffic Safety—Referred to Reference Committee on Hygiene and Public Health.

Tuberculosis—Dr. J. V. Pace, chairman, presented the report of the committee as printed in the Handbook and the following supplementary report, which were referred to the Reference Committee on Hygiene and Public Health:

WHEREAS it has been determined by the State and County Tuberculosis Associations and the State Board of Health that Indiana is short of beds for the care and treatment of tuberculosis in the number of at least five hundred, this Committee on Tuberculosis requests that your body go on record as approving the establishment of five hundred such beds as expediently as possible; it being understood that some of these beds would be added to existing tuberculosis hospitals and others would be added to various county and city general hospitals where they might be used to best advantage not only for the direct benefit of the patients but for teaching and research purposes as well.

We believe that such approval by the House of Delegates would carry great weight when it comes time for the necessary actions of Legislatures and Boards and certainly such a program would go a long way toward completing Indiana's tuberculosis armamentarium.

Venereal Disease—Referred to Reference Committee on Hygiene and Public Health.

Veterans Affairs and Rehabilitation—Referred to Reference Committee on Miscellaneous Business.

Journal Editor—Referred to Reference Committee on Reports of Officers.

Communications

On motion of Drs. Nafe and Wright, the executive secretary was instructed to telegraph best wishes for a speedy recovery to Dr. A. P. Hauss, president, who was unable to attend the meeting due to illness.

On motion of Drs. Charles N. Combs and Nafe, the House directed that a note of sympathy and best wishes be sent to Dr. William R. Davidson, Evansville, past president, who is ill.

Election of Indiana "General Practitioner of the Year"
—Following the procedure instituted at the 1948 annual session for the selection of the "General Practitioner of the Year," the chairman of the Council announced that the Council had selected the following three physicians for consideration of the House for this award:

Charles C. Crampton, Delphi,
Walter F. Kelly, Indianapolis,
David D. Todd, Elkhart.

At the suggestion of the Council, the following delegates talked briefly on behalf of these candidates:

Dr. F. S. Crockett for Dr. Crampton; Dr. R. M. Dearmin for Dr. Kelly; and Dr. S. T. Miller for Dr. Todd.

On ballot vote, Dr. Charles C. Crampton, of Delphi, was elected "General Practitioner of the Year."

New Business

1. *Certification of members for honorary membership.* The chairman asked that if there were any additional names to be handed in, the lists be brought to the desk. These nominations were referred to the Reference Committee on Miscellaneous Business.

2. *Supplementary report of Chairman of Council.* Dr. Alfred Ellison read the following resolutions which had been adopted by the Council and were being referred to the House for its consideration:

a. *Resolution creating a Grievance Committee,* which was referred to the Reference Committee on Miscellaneous Business:

"WHEREAS, The medical profession of the United States is engaged in a struggle for its very existence and it is requesting public support of the present system of medicine; and

"WHEREAS, The profession is cognizant of the fact that to gain the support of the public in this effort we must maintain good public relations and fulfill our obligations of service to the satisfaction of the public that we may continue our freedom in the practice of medicine; and

"WHEREAS, The misdeeds of a few of our profession receive widespread publicity, reflecting public disfavor upon the entire profession; and

"WHEREAS, The public feels it has no recourse for its just complaints; and

"WHEREAS, It is difficult for small units of our society to police the offenders;

"Now, Therefore Be It Resolved, That a grievance committee be created by the House of Delegates, consisting of the five living immediate past presidents of the Indiana State Medical Association, which committee would review complaints both from within the profession and from the general public; that this committee be empowered to act in the interest of good medical ethics; and that the establishment of such a committee be given wide publicity and full support of the physicians."

b. *Resolution regarding increase in membership dues,* which was referred to the Reference Committee on Miscellaneous Business:

"Resolved, That the membership dues, beginning with the year 1950, shall be \$35.00 per year."

c. *Resolution concerning assistant treasurer,* which was referred to the Reference Committee on Reports of Officers:

"Resolved, That the position of assistant treasurer be and hereby is created and that it be filled by appointment by the Council, and that the Council prescribe the duties to be performed by such officer."

d. *Resolution recommending collection of Woman's Auxiliary dues,* which was referred to the Reference Committee on Miscellaneous Business:

"Resolved, That the county society secretaries be encouraged to assist in the collection of the dues of the Woman's Auxiliary to the Indiana State Medical Association at the time the collection is made of the dues for membership in this Association."

e. *Resolutions regarding changes in By-laws,* which were referred to the Reference Committee on Amendments to Constitution and By-laws:

(1) "Resolved, That Chapter V, Section 4, of the By-laws be amended to read as follows:

"The President, President-elect, and the Treasurer shall serve from the termination of the annual convention in which the President-elect and Treasurer are elected until the termination of the succeeding annual convention."

(2) "Resolved, That Chapter XI, Section 12, be amended as follows: By striking out the last sentence and substituting in lieu thereof the following:

"Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$5.00 as dues for the remainder of that year."

(3) "Resolved, That Chapter XIII, Section 1, be amended to read as follows:

"One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense."

(4) "Resolved, That Chapter VI, Section 3, of the By-Laws be amended as follows, reference being made to the By-Laws as printed in the September JOURNAL and the Handbook for the House of Delegates:

"By striking out the following sentence 'He shall pay money out of the treasury only on a written order by the President, countersigned by the Chairman of the Council,' and by substituting in lieu thereof the following:

"The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council."

3. *Supplemental report of Indiana A.M.A. Campaign Coordinating Committee.* Dr. Cleon A. Nafe, Indianapolis, chairman of the Indiana A.M.A. Campaign Coordinating Committee, presented the following supplementary report, which was referred to the Reference Committee on Miscellaneous Business:

At the last meeting of this committee, since writing the report which was published in the September JOURNAL, Mr. Waggener, our field secretary, presented an elaborate public relations and publicity campaign proposal, based on newspaper, radio, and billboard advertisements on a state-wide basis, for the purpose of better informing our people concerning compulsory health insurance.

Proposals of two advertising agencies were received. This report was given as a result of a request by the committee, for the preparation of advertising material for use by individual county medical societies in their public relations programs.

Several county medical societies have been carrying paid advertisements in their local newspapers, and some of these societies had requested material from state headquarters for use locally.

The state-wide publicity program, which I have asked Mr. Waggener to present to you briefly in a moment, is very elaborate, and if paid for by the state association, and if carried out in full, would cost approximately \$100,000 for a year.

Our committee has referred this proposal to the Council, for their consideration, without recommendations. They are referring it to the House of Delegates, and requesting an increase in dues, which will enable the A.M.A. Coordinating Committee and the Public Relations Committee to follow through with the program in part.

It was the committee's original intention that the state association would furnish the material and that the local medical societies would use the copy when they wished and would pay for the same.

However, in order that the program would be uniform and state-wide, it is now proposed that the state association carry the major cost of these local programs.

It is the desire of this committee, which was created only this year, to ascertain from our physicians through this House of Delegates how extensive a program of publicity they wish carried out in this state, to combat the threat of the federalization of medicine.

Public Relations experts tell us that physicians do not spend enough time and effort in informing the public about the great achievements of the medical profession. They call attention to the fact that every business spends at least 1 percent of its income for publicity and improving public relations. They call attention to the fact that the combined income of the physicians in this state is probably in excess of \$20,000,000. An adequate public relations program for our medical society should cost $\frac{1}{2}$ to 1 percent, or from \$100,000 to \$200,000.

We have been informed that many state medical societies, particularly California, Michigan, Ohio, Pennsylvania, et cetera, at this time are carrying on an extensive public relations campaign.

It is the desire of this committee that this House of Delegates be fully informed concerning the problem, and await your instruction as to how extensive a program of public relations and publicity they wish carried out and to support financially.

We urge that you give this problem your serious consideration.

4. *Resolution on control of rabies.* Dr. Lowell F. Beggs, Columbus, presented the following resolution, which was referred to the Reference Committee on Hygiene and Public Health:

WHEREAS rabies is a Hoosier disgrace according to a recent State Rabies Advisory Committee, there being in 1947, 766 dog specimens received by the Indiana State Board of Health with 365 positive reports, and

WHEREAS each year approximately 475,000 people in the United States are bitten by dogs, of these about 30,000 are required to take Pasteur treatment, and

WHEREAS one out of 3,500 people who take Pasteur treatment become paralyzed and one out of 10,000 who take Pasteur treatment will die, and

WHEREAS the United States Public Health Service estimates rabies causes an annual loss of 5,000,000 dollars, and

WHEREAS Maine, Vermont, Massachusetts, and Rhode Island, England and Scandinavia have eliminated rabies,

Be It Hereby Resolved, That the House of Delegates of the Indiana State Medical Association direct our Legislative Committee to work with appropriate agencies in obtaining legislation by our next legislature to control and eradicate this dreaded disease.

5. *Resolutions on increase in specialization*, presented by Dr. R. M. Dearmin, Indianapolis, and referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, there has been an alarming increase in specialization within the Medical Profession; and

WHEREAS, this increase, if unchecked, will inevitably destroy our present system of medical practice and will aid those who favor the socialization of medical practice; now

Therefore, Be It Resolved that the House of Delegates of the Indiana State Medical Association in convention assembled go on record as favoring the requirement that every medical graduate spend three years in general practice as a prerequisite for training in a specialty, with the understanding that time spent in military service is to be considered as time spent in general practice; and

Be It Further Resolved that delegates from this Association be instructed to carry this resolution before the next regular meeting of the House of Delegates of the American Medical Association in convention assembled.

6. *Resolutions on establishment of general practice residencies and internships*, introduced by Dr. R. M. Dearmin, Indianapolis, and referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS, there is a great need for more well-trained physicians in the General Practice of Medicine;

WHEREAS, many Medical Schools are rapidly changing their emphasis to General Practice;

WHEREAS, most of the better hospitals now have a General Practice section of their staff;

Therefore, Be It Resolved that the Indiana State Medical Association, by action of its House of Delegates, does hereby endorse and urge the establishment of General Practice residencies and internships in the hospitals of this state and throughout the United States;

Furthermore, Be It Resolved that the establishment of such residencies and internships be given wide favorable publicity to encourage good students to take such appointments;

Furthermore, Be It Resolved that the Delegates from this state to the House of Delegates of the American Medical Association be instructed to introduce this Resolution in the next meeting of the House of Delegates of the American Medical Association in convention assembled.

7. *Resolutions on training of laboratory technicians for physicians' offices.* Dr. R. M. Dearmin, Indianapolis, presented the following resolutions, which were referred to the Reference Committee on Medical Education and Hospitals:

WHEREAS there is a shortage of qualified persons trained to do office laboratory work;

WHEREAS there is a shortage of qualified laboratory technicians for hospitals and private pathology laboratories;

WHEREAS the various certifying "Boards" are insisting on training only people to be accredited technicians and, therefore, there are no schools available for training office assistants to do the laboratory work desired in the average office;

WHEREAS most physicians cannot afford to pay an accredited technician full time for office work and accredited technicians do not like office jobs as it limits the use of their knowledge;

WHEREAS the judicious use of laboratory techniques in a doctor's office tend to make him a more efficient physician and thus render better medical service to his patients;

Therefore Be It Resolved that the Indiana State Medical Association, through its House of Delegates in convention assembled, does hereby approve and urge the establishment of a training course for office assistants in the techniques of blood counts, urinalysis, basal metabolism tracings, and such other simple laboratory procedures as it is feasible to teach in such a short course; such course to be established by Indiana University, either at the Medical Center or at the Extension Centers of the state, or at other accredited laboratories within the state of Indiana.

Furthermore Be It Resolved that such a course be set up to teach only office assistants in these laboratory procedures and that such assistant be admitted to this course only if he or she be a high school graduate or its equivalent, if he or she is in the active employment of the physician who sponsors said assistant in the course, and shall have passed an appropriate aptitude test to be devised by the proper authorities of Indiana University.

Furthermore Be It Resolved that this course be designed to be given in a limited period of 6-8 weeks in summer or as a night school course in winter and that this course follow reasonably near the following schedule:

Hematology (including orientation and microscope instruction.)	
RBC -----	20 hours
WBC -----	20 hours
Hbg. -----	10 hours
Sed. rate -----	10 hours
Diff. -----	50 hours
	<hr/> 110 hours
Urinalysis:	
Sugar -----	5 hours
Alb. -----	5 hours
Other chem. tests -----	10 hours
Micro. -----	20 hours
	<hr/> 40 hours
Basal Metabolism test -----	10 hours
EKG -----	20 hours
Procedures of an office nurse -----	10 hours
Reports -----	20 hours
Medical typing, record keeping -----	30 hours
	<hr/> 240 hours

GRAND TOTAL ----- 240 hours

8. Resolutions on national veterans' organizations.

Dr. R. M. Dearmin, Indianapolis, presented the following resolutions, which were referred to the Reference Committee on Public Policy and Legislation:

WHEREAS the American Legion and the Veterans of Foreign Wars are generally recognized as the most powerful veterans' groups in the United States; and

WHEREAS their actions carry great weight in the legislative halls of the state and nation; and

WHEREAS the medical profession needs the full support of these organizations in the profession's continuing battle against the attempts of cultists and charlatans to inflict their nefarious practices upon the veterans of the United States; now

Therefore Be It Resolved that the Indiana State Medical Association urge its component county societies to influence its eligible members to join these organizations and to interest themselves in affairs of the respective American Legion and Veterans of Foreign Wars posts; and

Be It Further Resolved that individual members of the Indiana State Medical Association be urged to keep in the closest contact with delegates to the state and national veterans' conventions and to advise with them in matters of medical importance.

9. Resolutions on "General Practitioner of the Year."

Dr. R. M. Dearmin, Indianapolis, presented the following resolutions, which were referred to the Reference Committee on Publicity:

WHEREAS it is deemed impossible for a group of physicians as large as the Indiana State Medical Association to have sufficient knowledge of the individual members to make intelligent selection of a "general practitioner of the year"; and

WHEREAS in the eyes of the general public the physician of each family group is properly considered as the "best doctor," which is as it should be for the best interest of the laity and the profession; and

WHEREAS if carried to its logical conclusion the plan should properly make provision for awards of the year to all branches of the practice of medicine; and

WHEREAS the profession should remain firmly united and present a solid front to the public in these days of socialistic external attacks upon it; now

Be It Resolved that the House of Delegates of the Indiana State Medical Association in convention assembled rescind its action of 1947 in authorizing selection of a "General Practitioner of the Year" from the State of Indiana; and

Be It Further Resolved that delegates of this Association to the American Medical Association present this resolution for consideration before the next regular session of the House of Delegates of the American Medical Association in convention assembled.

10. *Resolution on honorary membership for speakers on centennial program.* Dr. C. V. Rozelle, Anderson, presented the following resolution, which was referred to the Reference Committee on Sections and Section Work:

WHEREAS almost all speakers on the Centennial program are either Hoosier-born or Hoosier-educated, and

WHEREAS many of these men have attained outstanding reputations in their fields of work, and

WHEREAS many of them have repeatedly returned to address this and other Indiana Medical meetings at great personal sacrifice,

Therefore Be It Resolved That all speakers on this centennial program who are Hoosier-born or Hoosier-educated and who are not at present members of the state association be made honorary members of the Indiana State Medical Association by vote of this House of Delegates.

11. *Resolutions on treatment of chronic alcoholics.* Dr. Kenneth D. Schneider, Nashville, presented the following resolutions, which were referred to the Reference Committee on Public Policy and Legislation:

WHEREAS chronic alcoholics are a serious medical problem in the state of Indiana, and

WHEREAS there are no clinics or proper institutions for the treatment of these individuals, and

WHEREAS some states, notably Connecticut, are having success in solving this problem by study and care,

Be It Hereby Resolved that our Legislative Committee endeavor to get legislation to establish clinics and proper institutions for the treatment of chronic alcoholics;

Be It Further Resolved that our Legislative Committee attempt to get a law enacted to have uncooperative cases forcibly committed by a court order to a proper institution for the care of these cases.

Presentation of Picture of Dr. Livingston Dunlap

DR. JOHN ERIC DALTON, Indianapolis: At this time on the one-hundredth anniversary of the Indiana State Medical Association, I would like to present to the association this painting of Dr. Livingston Dunlap, to whom we owe so much for our present organization. This is the story of this picture:

During 1925-26, while assigned to student obstetrical service, I strolled down Indiana avenue. In a second-hand store, situated where Lockfield Gardens now stand, I noted a grimy portrait of a man in an old gold frame. Being interested in antiques, I inquired about it. Through the dirt, I believed it to be probably a Lincoln picture and I bought it for a dime. On cleaning it I was unable to identify the subject but found the name Dunlap written on the back.

Later I mentioned this to Dr. W. N. Wishard, Sr., and he directed me to bring it to him. When he saw it

he believed it to be an early portrait of Dr. Livingston Dunlap. Still later he compared it with his photograph of Dr. Dunlap, which was made at an older age, and he then identified it positively as the same man.

About that time, Mr. Wilbur Peat, Director of Herron Museum, became interested in whether an early Indiana artist did the painting. However, it is not signed and he was unable to identify it by technique. Nevertheless, he also compared this painting with the later photograph and regarded the two pictures as those of the same man at different ages.

Other medical groups, with whose founding Dr. Dunlap was associated, have sought this picture. However, I present it here. I feel it rightfully belongs to the Indiana State Medical Association, over whose first convention he presided as chairman.

General Practitioner of the Year

At this time the "General Practitioner of 1949," Dr. Charles C. Crampton, of Delphi, was brought to the stage and introduced. Addressing the House of Delegates he recounted some of his experiences during fifty-six years in the practice of medicine, concluding with "It's been a glorious fifty-six years, and I have had my triumphs and I have had my disappointments. I want to thank especially my own boys up around Carroll and Tippecanoe counties. I want to thank the Indiana State Medical Association for this great honor that it has conferred upon me. I wonder if I deserve it."

No further business appearing, the House of Delegates adjourned, to meet again at 11:00 a.m., Thursday, September 29, 1949, in the Auditorium of the Athenaeum.

HOUSE OF DELEGATES

(Indianapolis Session, 1949)

Second Meeting

The second meeting of the House of Delegates, a luncheon meeting, was called to order at 11:30 a.m., Thursday, September 29, 1949, by Dr. Augustus P. Hauss, president.

Dr. William E. Amy, chairman of the Reference Committee on Credentials, announced that a quorum was present.

It was taken by consent that attendance slips signed by the delegates, showing the following present, should constitute the roll call:

County	Delegates
Adams	Ben Duke, Decatur
Allen	Maurice E. Glock, Fort Wayne Arthur J. Roser, Fort Wayne H. Vaughn Scott, Fort Wayne Elmer C. Singer, Fort Wayne Herbert M. Senseny, Fort Wayne, alternate
Bartholomew	
Brown	Lowell F. Beggs, Columbus Kenneth D. Schneider, Nashville
Benton	V. L. Turley, Fowler
Boone	Jack Porter, Lebanon
Cass	E. B. Jewell, Logansport
Clark	E. P. Buckley, Jeffersonville
Clay	John M. Palm, Brazil Robert K. Webster, Brazil, alternate
Clinton	F. A. Beardsley, Frankfort
Dearborn-Ohio	J. Kenneth Jackson, Aurora Charles N. Manley, Rising Sun
Decatur	D. D. Dickson, Greensburg
DeKalb	Charles I. Weirich, Butler
Delaware	
Blackford	William T. Douglas, Montpelier O. A. Hall, Muncie Gerald S. Young, Muncie

County	Delegates
Elkhart	Sam Miller, Elkhart A. C. Yoder, Goshen
Fayette-Franklin	Frank H. Neukamp, Connersville
Floyd	John M. Paris, New Albany C. E. Briscoe, New Albany, alternate
Fountain-Warren	James W. Crain, Williamsport Lee J. Maris, Attica
Fulton	A. E. Stinson, Rochester
Gibson	Virgil McCarty, Princeton
Grant	Russell W. Lavengood, Marion
Hancock	Robert O. Scott, Charlottesville
Harrison	William E. Amy, Corydon
Hendricks	O. T. Scamahorn, Pittsboro
Henry	L. C. Marshall, Mt. Summit
Howard	Richard P. Good, Kokomo R. M. Evans, Russiaville, alternate
Huntington	Howard H. Marks, Huntington
Jasper-Newton	Frank G. Sink, Remington
Jay	George V. Cring, Portland
Jefferson	S. A. Whitsitt, Madison
Johnson	O. A. Province, Franklin
Knox	Virgil C. McMahan, Vincennes
Lake	H. W. Eggers, Hammond Ray Elledge, Hammond E. L. Schaible, Gary Michael Shellhouse, Gary H. R. Stimson, Gary William R. Troutwine, Crown Point Samuel J. Petronella, East Chicago, alternate
Lawrence	Claude Dollens, Oolitic
Madison	C. V. Rozelle, Anderson G. B. Wilder, Anderson
Marion	R. M. Dearmin, Indianapolis Murray DeArmond, Indianapolis Bert E. Ellis, Indianapolis E. Vernon Hahn, Indianapolis R. D. Howell, Indianapolis Harry R. Kerr, Indianapolis H. C. Ochsner, Indianapolis F. B. Ramsey, Indianapolis O. W. Sicks, Indianapolis Sydney L. Stevens, Indianapolis Dan E. Talbott, Indianapolis J. M. Whitehead, Indianapolis Wm. Niles Wishard, Jr., Indianapolis J. William Wright, Indianapolis
Marshall	A. A. Thompson, Tynar
Miami	R. E. Wildman, Peru
Montgomery	James M. Kirtley, Crawfordsville Fred N. Daugherty, Crawfordsville, alternate
Morgan	Edward M. Pitkin, Martinsville
Noble	J. R. Nash, Albion
Orange	Keith Hammond, Paoli
Owen-Monroe	William A. Karsell, Bloomington Frederick A. Smith, Spencer
Parke-Vermillion	B. M. Merrell, Rockville S. C. Darroch, Cayuga
Pike	Milton H. Omstead, Petersburg
Posey	William B. Challman, Mt. Vernon
Putnam	James B. Johnson, Greencastle
Ripley	Lowell G. Hunter, Milan
Rush	Melvin H. Denny, Rushville
St. Joseph	E. Blackburn, South Bend F. R. Nicholas Carter, South Bend A. S. Giordano, South Bend Marshall I. Hewitt, South Bend
Scott	Floyd S. Napper, Scottsburg
Shelby	W. D. Inlow, Shelbyville
Starke	Guy B. Ingwell, Knox
Sullivan	C. F. Briggs, Sullivan
Switzerland	L. H. Bear, Vevay

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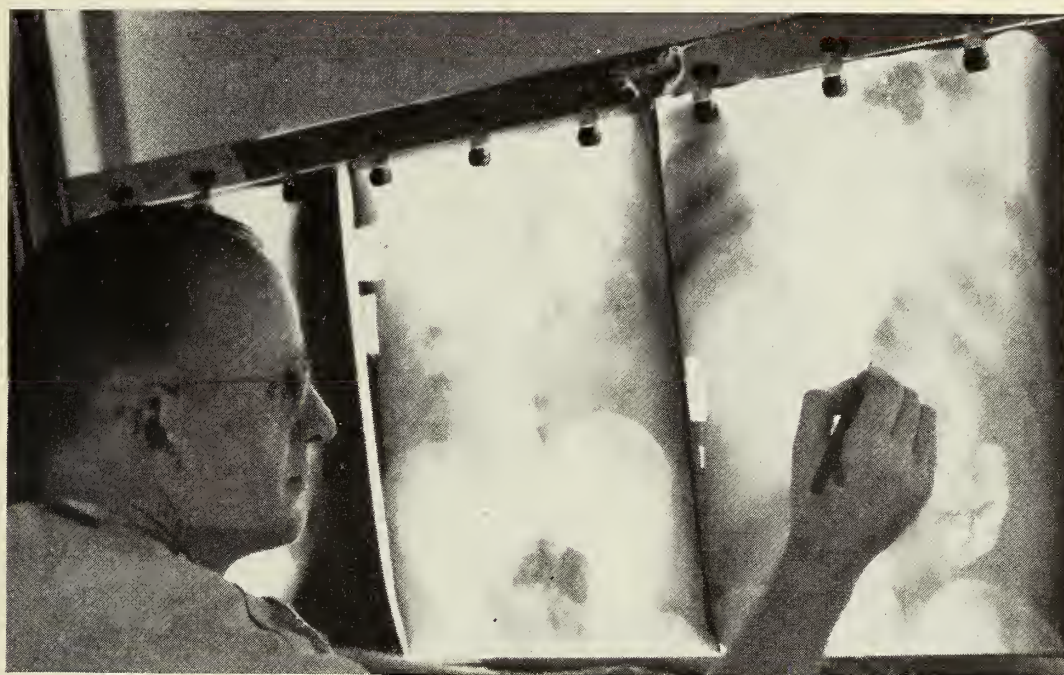
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	C. C. Herzer, Evansville
	Minor Miller, Evansville
Vigo	Ernest O. Nay, Terre Haute
	M. C. Topping, Terre Haute
Wabash	F. M. Whisler, Wabash
Warrick	J. Guy Hoover, Boonville
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1st District	Herman T. Combs, Evansville
2nd District	William C. Reed, Bloomington
3rd District	William H. Garner, New Albany
4th District	George A. May, Madison
5th District	A. M. Mitchell, Terre Haute
6th District	W. U. Kennedy, New Castle
7th District	C. J. Clark, Indianapolis
8th District	E. H. Clauser, Muncie
9th District	W. Dodds, Crawfordsville
10th District	W. H. Howard, Hammond
11th District	Elton R. Clarke, Kokomo
12th District	Paul A. Garber, South Whitley
13th District	Alfred Ellison, South Bend

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 N. K. Forster, Pacific Palisades, California
 J. E. Ferrell, Fortville
 Floyd T. Romberger, Lafayette
 Cleon A. Nafe, Indianapolis

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Augustus P. Hauss, New Albany, president
 C. S. Black, Warren, president-elect
 A. F. Weyerbacher, Indianapolis, treasurer
 W. L. Portteus, Franklin, Executive Committee member
 Albert Stump, Indianapolis, attorney for association
 Ray E. Smith, executive secretary
 James A. Waggener, field secretary

Delegates to A.M.A.

H. G. Hamer, Indianapolis
 William M. Cockrum, Evansville
 E. S. Jones, Hammond, alternate

Distinguished Guests

The president introduced the following guests:

George F. Lull, M.D., secretary and general manager, American Medical Association
 L. H. South, M.D., representing the Kentucky State Medical Association
 Lawrence W. Rember, executive assistant, American Medical Association
 Thomas A. Hendricks, secretary, Council on Medical Service, American Medical Association, and executive secretary emeritus, Indiana State Medical Association.

Charles S. Nelson, executive secretary, Ohio State Medical Association

George H. Saville, assistant executive secretary and director of public relations, Ohio State Medical Association

THE PRESIDENT: Inasmuch as a quorum is present, the first business at this time is the election of a president-elect.

Election of Officers

Election of officers resulted as follows:

President-elect, 1950 — Alfred Ellison, South Bend

Treasurer — A. F. Weyerbacher, Indianapolis

Delegates to A.M.A. for term expiring

December 31, 1951 — F. S. Crockett, Lafayette

William M. Cockrum, Evansville

Alternates — A. M. Mitchell, Terre Haute

Cleon A. Nafe, Indianapolis

DR. ALFRED ELLISON: Gentlemen, ladies: I find it quite a little difficult to know how to thank you for this very distinguished honor, but I do want each of you to know that I appreciate it deeply, and I shall try, when my year comes up, in 1951, when Doctor Black turns over the gavel to me, to justify the confidence that you have placed in me now. There can be no doubt in the minds of all of us that in the future we must not only be good, outstanding, virile doctors, but good Americans as well. So, I would like to adopt for '51, as Doctor Black has adopted "Service" this year for his slogan, the slogan "Americanism." Thank you very, very much.

Place of 1951 Annual Session

On invitation of the Indianapolis Medical Society, extended by Dr. R. M. Dearmin, the 1951 annual session will be held at Indianapolis.

Elections of Councillors

Elections of councillors to replace those whose terms will expire December 31, 1949, were reported as follows:

3rd District—William H. Garner, New Albany, re-elected

6th District—W. U. Kennedy, New Castle, re-elected

9th District—Wemple D. Dodds, Crawfordsville, re-elected

12th District—M. B. Catlett, Fort Wayne

Reports of Reference Committees**SECTIONS AND SECTION WORK**

Dr. Ernest P. Buckley, chairman, presented the following report, which on motions of Dr. Buckley, duly seconded and carried, was adopted section by section and as a whole.

The reference committee feels that the scientific work of this session of the Indiana State Medical Association has been on a very high plane and deserves the commendation of the House of Delegates, and that the Committee on Scientific Work be commended for the splendid program.

The instructional courses were well organized; the details of enrollment were well taken care of. The courses were exceptionally well attended. We therefore recommend that the present arrangement of instructional courses be continued and the Committee on Instructional Courses be highly commended for their splendid work. I move the adoption of this report.

Your committee feels that the scientific exhibits at this session are outstanding and are comparable only to those of the American Medical Association. The Committee on Scientific Exhibits is to be highly commended and extended the thanks of this House of Delegates. I move the adoption of this report.

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After due consideration of the resolution regarding honorary membership, reference was made to Article IV, Section 5 (bold face) of the Constitution of the Indiana State Medical Association which reads, "Honorary members shall consist of teachers, scientists, and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor."

Your reference committee feels that the Constitution of the Indiana State Medical Association should be followed and any proposal for honorary membership to this association be considered individually. Your committee therefore recommends that this resolution be tabled.

We move the adoption of this report as a whole.

ERNEST P. BUCKLEY, M.D., Chairman
R. R. CALVERT, M.D., Vice-Chairman
KEITH HAMMOND, M.D.
E. M. PITKIN, M.D.
A. C. NICKEL, M.D.

The motion of Drs. C. V. Rozelle and C. J. Clark to remove from the table the resolution regarding honorary membership in the state association for guest speakers was lost on a standing vote.

RULES AND ORDER OF BUSINESS

Nothing having been referred to this committee, there was no report.

MEDICAL EDUCATION AND HOSPITALS

Dr. C. H. McCaskey, chairman, presented the following report, which was adopted section by section and as a whole, on motions of Dr. McCaskey, duly seconded and carried.

We have reviewed the reports of the standing Committee on Medical Education and Hospitals and the Committee on Medical and Nursing School Scholarships and move that they be approved as printed in the Handbook for the House of Delegates.

We recommend that the following changes be made in the resolution regarding specialization which was introduced by the chairman of the Marion county delegation:

That the word "alarming" be omitted from the first paragraph, that the second paragraph be completely deleted, and that paragraph three be revised to read as follows:

"Therefore, Be It Resolved that the House of Delegates of the Indiana State Medical Association in convention assembled go on record as favoring three years in general practice as desirable for training in a specialty with the understanding that time spent in military service is to be considered as time spent in general practice";

This resolution, therefore, as we wish it amended, will read as follows:

"WHEREAS, there has been an increase in specialization within the Medical Profession;

"Therefore, Be It Resolved that the House of Delegates of the Indiana State Medical Association in convention assembled go on record as favoring three years in general practice as desirable for training in a specialty with the understanding that time spent in military service is to be considered as time spent in general practice; and

"Be It Further Resolved that delegates from this Association be instructed to carry this resolution before the next regular meeting of the House of Delegates of the American Medical Association."

We move the adoption of this resolution as amended.

The resolution regarding the establishment of General Practice residencies and internships is approved as introduced. We move the adoption of this resolution.

The resolution introduced by the delegate from Marion County concerning the training of technicians for phy-

sicians' offices was not approved by the reference committee. We wish to submit the following amended resolution for your consideration. We think the training of technicians for physicians' offices is a worth-while endeavor but that it needs further study. Therefore we recommend that a committee be created composed of the following membership:

1. Two members to be appointed from the Indiana State Medical Association.
2. Two members to be appointed by the Indiana Academy of General Practice.
3. Two members from the Indiana Association of Pathologists.
4. Two representatives from the Indiana University School of Medicine, to be selected by the dean of the Medical School.

We recommend that a report of this study be made at the spring meeting of the Council of the Indiana State Medical Association in 1950. I move the adoption of this amended resolution.

I move the adoption of this report as a whole.

C. H. McCASKEY, M.D., Chairman
C. J. CLARK, M.D., Vice-chairman
I. E. HUCKLEBERRY, M.D.
MURRAY DeARMOND, M.D.
ELMER SINGER, M.D.

PUBLIC POLICY AND LEGISLATION

Dr. F. R. Nicholas Carter, chairman, presented the following report, which was adopted section by section and as a whole, on motions of Dr. Carter, duly seconded and carried:

The Reference Committee on Public Policy and Legislation has reviewed the report of the Standing Committee on Public Policy and Legislation. This committee is to be highly commended for its untiring efforts to stem the tide of paternalism that has been so fulminating in legislative circles during the past year.

Special attention is called to the section dealing with chiropractors and their efforts to enlist veterans' organizations to promote their own special interests.

Since this report has been written certain legionnaires as well as the Paul Coble Post No. 26 and the Lawrence Capehart Post of this great organization have done valiant service for the cause of organized medicine, at their convention held in Philadelphia, August 30, 1949. The reference committee feels that these laymen and these posts of the American Legion should be informed of our gratitude for their consideration. With this additional suggestion, your committee recommends the acceptance of the report of the Committee on Public Policy and Legislation, and I so move.

The Reference Committee on Public Policy and Legislation has reviewed the report of the Committee on Public Relations. The work carried on by this committee throughout the year is of great importance. The committee is to be commended for its effort.

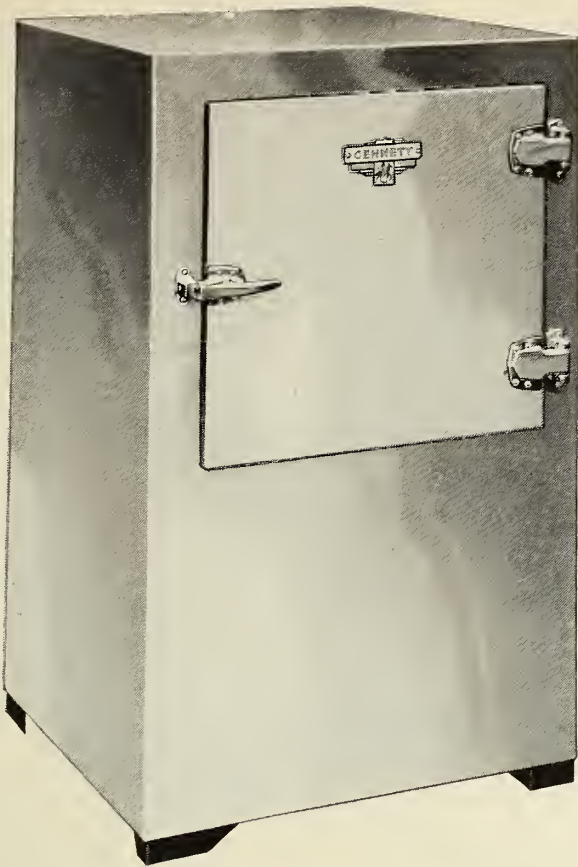
The personal letters from Dr. Hauss to each member of the legislature were of great value in creating good will.

The monthly "I.S.M.A. News Flashes" are important in making every member of our society feel that he is an integral part of organized medicine. The reference committee feels that this has been a good move and should be continued.

The Committee on Public Relations is to be congratulated for its close work with the local units of the Woman's Auxiliary. Soliciting their aid to promote our cause is logical and represents intelligent thinking.

Your reference committee recommends the acceptance of the report of the Committee on Public Relations as written, and I so move.

Your reference committee has reviewed the report of the Committee on Crippled Children Services and Infantile Paralysis. Since this committee represents two types of medical activity we feel that the committee has wisely pointed out that this committee should be two



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committees instead of one. We therefore recommend that the committee be divided into a Committee for Crippled Children's Services and a Committee on Infantile Paralysis.

The widespread incidence of polio throughout the state during the present year has brought to our attention the importance of this disease entity. It has also revealed the fact that uniform practices should be set up throughout the state for its control. These practices should be uniform from the viewpoint of hospital care, nursing, quarantine, and isolation of contacts, as well as in the economy that surrounds the care for the illness. Your reference committee suggests that a study be made by such an infantile paralysis committee and that its findings be submitted to the Council and State Board of Health for adoption before another so-called polio season occurs. We recommend acceptance of the report as written with this additional comment and I so move.

Your Reference Committee on Public Policy and Legislation has reviewed the report of the Committee on Indigent Medical Care. We are aware of the difficulty incurred in finding a suitable definition for the so-called indigent.

Our reference committee wishes to commend the report of this committee relative to the handling of indigency from the office of the local township trustee. We agree that the increasing tendency to carry out indigent care from state and national levels is a tendency toward paternalistic medicine and should be discouraged. We recommend adoption of the report of the committee as written, and I so move.

Your Reference Committee on Public Policy and Legislation has reviewed the report of the Committee on Maternal and Child Health. Of particular interest to this reference committee was the effort that the committee has made toward the proper handling of mentally defective children under six years of age. Our state facilities have been inadequate for this type of care. This action on the part of this committee is highly commendable. The reference committee recommends the acceptance of the report as submitted, and I so move.

Your Reference Committee on Public Policy and Legislation has reviewed the report of the Committee on Rural Health and wishes to commend the effort which this committee and its chairman have expended.

The committee wishes to call your attention to the following paragraph taken from this report:

"It was suggested at this meeting that one of the first problems of a newly-created county health council should be to survey the health needs of its community. From that study should come clear recognition of one big problem which the health council could take immediate steps to remedy. It was the committee's feeling that Hoosier doctors should be the authority and guide in all medical thinking done by the councils. It was also suggested that there is a need for awakening Indiana doctors to the necessity for working with lay groups interested in health improvement on the community level; that being in personal touch with lay groups would give the medical profession valuable clues as to the thinking of the public toward medicine, and would help us orient ourselves in the fight against socialized medicine."

"General discussion brought out that county health councils usually lacked strong leadership and certainly one of the first steps in reorganizing such groups would be to appoint a recognized and responsible leader. Doctor Barrett suggested that Hoosier doctors need to be informed on what a county health council should do, then they, the doctors, should assume the leadership and general guidance."

Your committee feels that this report is very important and we recommend its acceptance, and I so move.

A resolution pertaining to the relationship of our state and local medical societies to the American Legion, the Veterans of Foreign Wars and other like organiza-

tions, submitted by the Indianapolis Medical Society, was reviewed by this Reference Committee on Public Policy and Legislation. We recommend its acceptance, and I so move.

A resolution from the Bartholomew-Brown County Medical Society regarding chronic alcoholics was reviewed by the Reference Committee on Public Policy and Legislation. Our committee feels that private organizations are carrying out valuable services in the care of the chronic alcoholic. The advisability of taking away this activity from these organizations and placing it in the hands of state control is questionable. Our committee feels that more time should be allowed to elapse before a definite conclusion is reached relative to this difficult problem. We therefore recommend that the resolution be tabled for further consideration at a later date, and I so move.

I move the adoption of this report as a whole.

F. R. N. CARTER, M.D., Chairman
JOHN M. PARIS, M.D., Vice-chairman
E. H. CLAUSER, M.D.
GEORGE V. CRING, M.D.
V. L. TURLEY, M.D.

PUBLICITY

Dr. William N. Wishard, Jr., chairman, presented the following report, which, on motion of Dr. Wishard, duly seconded and carried, was adopted with one amendment, as noted below:

The report of the Committee on Publicity was read and approved, with commendation unanimously.

The report of the Committee on Centennial History and Publications was read and unanimously approved. The committee expresses its appreciation and thanks to the Committee on Centennial History and Publication for its long, painstaking and fruitful work, and commends the volume of the History of the State Medical Association which it has published.


The report of the Committee on Historical Exhibits embodied in an article published by Dr. Rice in the September number of THE JOURNAL was unanimously approved, with special commendation to Dr. Rice and the members of his committee, which has brought before us such a fine, graphic history of our Association. Much of this work Dr. Rice did during a recent illness and we all hope for him a speedy recovery, and are glad he is again able to be out.

The report of the Committee on State Fair, together with a supplementary report, was unanimously approved.

The resolution introduced by the chairman of the Indianapolis Medical Society delegation was read and debated on both sides. The committee made an attempt to sound out an opinion on this matter, both before and during its meeting, and held a hearing during the meeting. It was the view of the committee that although many general practitioners throughout the state are unquestionably equally deserving of citation, nevertheless it is a fine thing, particularly for the public relations of the association, to place before the public a general practitioner of the year. The Reference Committee on Publicity unanimously recommends to the House of Delegates that we continue the General Practitioner Award and further recommends that information on candidates in the future be sent only to the Chairman of the Council, and that selection of candidates be strictly limited to general practitioners in rural areas.

WM. N. WISHARD, JR., M.D., Chairman
GORDON A. THOMAS, M.D., Vice-chairman
WILL A. THOMPSON, M.D.
WEMPLE DODDS, M.D.
HERMAN T. COMBS, M.D.

Following discussion by Drs. Thomas, Crain and Romberger, on motion of Drs. Nafe and Giordano, the report was amended by striking out the last three words of the last sentence, making it read, "and that selec-



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tion of candidates be strictly limited to general practitioners."

Luncheon

The House adjourned to the East Room of the Antheum for luncheon, during which Dr. Sensenich, Mr. Hendricks and Dr. Lull made brief talks.

Dr. Rufus B. Robins, Camden, Arkansas, a member of the A.M.A. Coordinating Committee for the Protection of the People's Health, addressed the members of the House on "The A.M.A. Coordinating Committee and Its Accomplishments."

Following lunch, the House resumed its business in the Auditorium.

Reports of Reference Committees

AMENDMENTS TO CONSTITUTION AND BY-LAWS

Dr. Paul D. Crimm, chairman, presented the following report, which on motions of Dr. Crimm, duly seconded and carried, was adopted section by section and as a whole.

Your Reference Committee on Amendments to Constitution and By-Laws desires to know your pleasure as to what procedure you wish to employ in adopting the revised Constitution and By-Laws for this association.

Procedure 1—Do you desire to have the entire subject matter read in detail and vote on each section separately, or

Procedure 2—To read each section by title only and vote on each section separately, or

Procedure 3—To read in detail and vote on the four amendments submitted to the 1949 meeting of the House of Delegates and then vote on the report as a whole, since it has been voted on by this delegation in 1948 and published twice in THE JOURNAL? (By consent, procedure 3 was adopted.)

Chapter V, Section 4 of the By-Laws:

The old section reads, "The President, President-elect, and the Treasurer shall serve from the termination of the annual convention in which the President-elect and Treasurer are elected until the termination of the succeeding annual convention."

Resolved, That Chapter V, Section 4, of the By-Laws be amended to read as follows:

"The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates."

Chapter VI, Section 3 of the By-Laws:

The old section reads, "He shall pay money out of the treasury only on a written order by the President, countersigned by the Chairman of the Council."

Resolved, That Chapter VI, Section 3, of the By-Laws be amended to read as follows:

"The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council."

Chapter XI, Section 12 of the By-Laws:

The old section reads, "Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$5.00 as dues for the remainder of that year."

Resolved, That Chapter XI, Section 12, be amended as follows:

By striking out the last sentence and substituting in lieu thereof the following:

"Provided, however, that physicians elected to their first membership in this Association during the first

nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay \$10.00 as dues for the remainder of that year. Interns and residents shall pay \$10.00 a year annual dues during their term of service in the hospital."

Chapter XIII, Section 1 of the By-Laws:

Resolved, That Chapter XIII, Section 1, be amended to read as follows:

"One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense."

Your Reference Committee on Amendments to Constitution and By-Laws has carefully studied the many changes and additions which have been made by the standing Committee on Constitution and By-Laws, of which Dr. I. C. Barclay is chairman and Drs. Gordon A. Thomas, A. W. Cavins, Claude D. Holmes, Joseph Lang and W. Donald Close are members. We wish to commend them for their excellent and painstaking work, so well and ably performed. Your Reference Committee therefore wishes to recommend that the entire report of the Committee on Constitution and By-Laws as printed, and as amended at this 1949 meeting of the House of Delegates be adopted as a whole.

Your Reference Committee on Amendments to Constitution and By-Laws recommends that the Executive Committee study the question of limiting the indemnity to the assured for his personally chosen attorney to a fee of \$75.00 a day in medical defense suits.

PAUL D. CRIMM, M.D., Chairman
CLEON A. NAFE, M.D., Vice-chairman
A. M. MITCHELL, M.D.
F. S. CROCKETT, M.D.
J. E. FERRELL, M.D.

HYGIENE AND PUBLIC HEALTH

Dr. Harry P. Ross, chairman, presented the following report, which on motions of Dr. Ross, duly seconded and carried, was adopted section by section and as a whole, with amendments as noted:

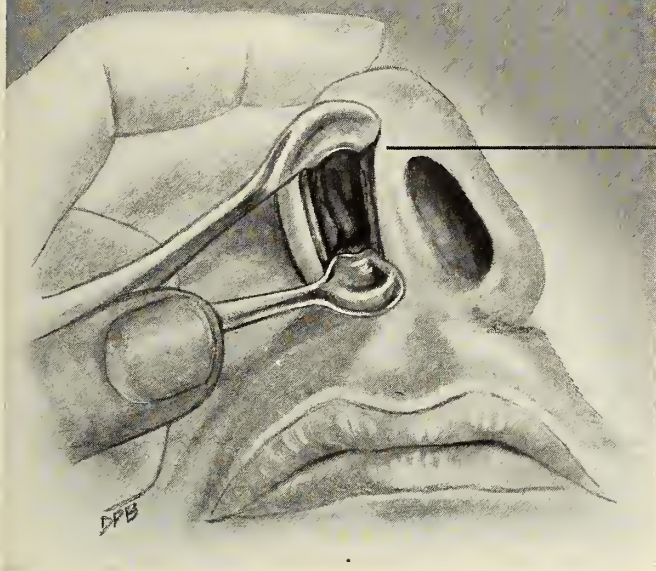
Your Reference Committee on Hygiene and Public Health submits the following report and recommendations:

(1) *Report of Committee on Cancer.* Careful consideration was given to the report of the Committee on Cancer. We commend this report to the House of Delegates and the committee for its large amount of work and continuing interest in this program. We recommend the adoption of the report as printed in the Handbook.

(2) *Report of Committee on Conservation of Vision.* We commend the chairman of this committee for his interest in the program and the time that he has spent attending related meetings of other organizations. We commend the other members of the committee for their continued interest and recommend the adoption of the report as printed in the Handbook.

(3) *Report of Committee on Diabetes.* Your reference committee has given detailed and lengthy consideration to the problems involved in the work of this particular committee. We have discovered that there is considerable misunderstanding on the part of many members of the medical profession at large throughout the state of Indiana and even among the members of the House of Delegates, regarding the activities of this particular committee. We have learned that the United States Public Health Service had plans laid to step into the state and make their own survey on a state-wide basis for diabetes detection. We commend this regularly appointed standing committee of the state medical association for the great amount of time, effort and self-sacrificing service that it has devoted to setting up a program that is consistent with the avowed policies expressed by this House of Delegates upon many occasions. This program permits Diabetes Detection

promotes
aeration . . . free drainage
in colds
. . . sinusitis



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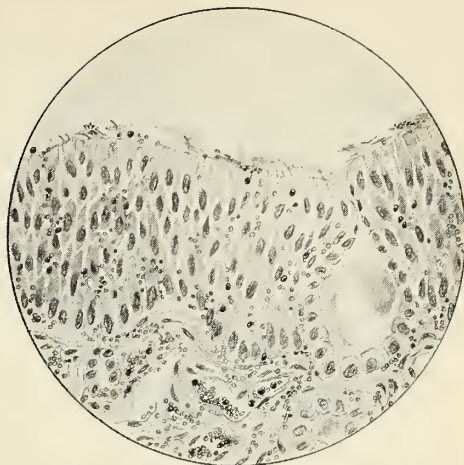
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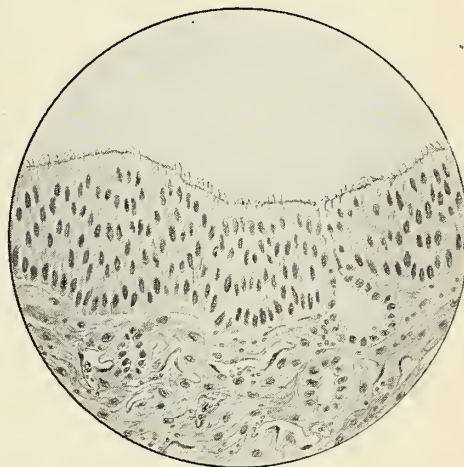
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Nasal membrane showing increased leukocytes with denudation of cilia.

Normal appearing nasal epithelium.



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Week to be handled by the medical profession itself under its auspices, on a local basis, sponsored by the local county medical society. Therefore, Mr. President, we move adoption of the report as printed and further urge the support of all county medical societies to carry out the program without the support, or aid, or supervision of any governmental agency.

(4) *Committee on Hard of Hearing.* We commend this committee for its activity and extensive interest in the program of hearing conservation and rehabilitation. We recommend that the suggestions embodied in the report of this committee be activated and that the House of Delegates approve the association of its members in the program as outlined. We move the adoption of this report.

(5) *Committee on Heart Disease.* We commend this committee and all of its members for their interest in this phase of medicine and for the vast amount of time that each member has spent attending many meetings related to this subject. It was unanimously agreed by your reference committee that lines 4, 5 and 6 of the right hand column on page 32, reading "It further feels that this study should be carried out in a community having a full-time health officer" should be deleted and that the report as revised should therefore read, beginning with line 1, right hand column, page 32, "This committee favors a study of the methods available for discovering, treating and rehabilitation of heart disease patients. Finally, it was unanimously agreed by the members of the committee present that the local medical society elect the group to carry out the study and that this group determine the scope of the study to be carried out."

Mr. President, we recommend the adoption of the report with this deletion.

(6) *Report of Committee on Industrial Health.* We recommend the adoption of this report as printed.

(7) *Report of the Committee on Mental Health.* I quote directly the sense of the members of your reference committee regarding this report. It was moved and seconded and unanimously adopted that the report of the Committee on Mental Health as submitted in the Handbook be adopted and that the reference committee recommend to this House of Delegates that the standing committee of the State Medical Association on mental health continue to be active during the coming year. In view of the fact that public interest and legislative investigations into the custodial care and treatment of inmates of mental institutions have received wide publicity, and also in view of the state-wide building program for the care of these patients and the intense public interest manifested in the establishment of mental hygiene clinics, it is required that more active participation by the representatives of the medical profession and particularly the members of the Indiana State Medical Association be seen. Your reference committee begs leave to suggest that next year's committee bestir itself.

Mr. President, I move the adoption of this report.

DISCUSSION

DR. MURRAY DE ARMOND: As chairman of the Mental Health Committee, I accept the recommendations, but I should like to make these comments. We recognize that the magnitude of the mental health problems in this state, including the problems of the mental hospitals, indicate that the medical profession alone cannot solve all of these problems. Until some organization which will mobilize the energies of a large body of the citizenry of this state is set up and going, we feel that not too much progress is going to be made in approaching a solution of some of these questions.

I would like to make this comment in reference to the energies of the various members. Reference in that report was made to a letter which was sent out over

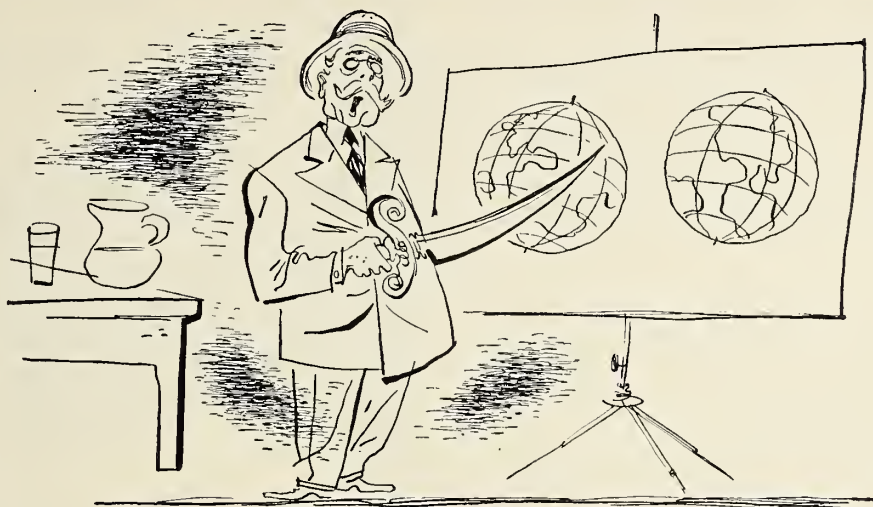
the committee's signature to each county medical society in the state, through the respective secretary. I believe that that letter did not attract the interest that it should, and for that reason I rise before the House of Delegates. The Mental Health Committee has actively participated in the reorganization of the Indiana Society for Mental Hygiene. Your chairman believes that that Mental Hygiene Society is now organized on an enduring basis and with sound medical direction. This report which came down to each county medical society gave the role and status of development of this Mental Hygiene Society. Further information will follow, I am sure, this year, and with ensuing committees. Very soon this organization will be in a position that each individual doctor can lend his support and guidance, and medical guidance is a most important need of any Mental Hygiene Society. With that kind of support and energy behind a movement, some of these problems can be approached and many of them can be solved. It is most important that this Indiana Mental Hygiene Society have the continued direction of an increasing number of individual doctors. I am quite sure the Indiana Mental Hygiene Society is going to flourish. It should grow and extend its influence, but we must be sure that this influence is in the right direction. The life and continuance of that society under the present organization and dynamic energy is not our problem. It is our problem to see that it is properly directed. I rise before this House of Delegates, because apparently the work of the Mental Health Committee through the Mental Hygiene Society has not aroused the proper interest through an effort to bring it down to every doctor in the society. I want to express my appreciation of the patience and tolerance of each member of the Mental Hygiene Committee during the period of organization and development of adequate machinery to cope with the mental health problems of the state. This same patience and tolerance is asked of the general membership of ISMA at a time when there are so many minor problems to confuse the goal and divert the essential energies.

DR. E. VERNON HAHN: Since the report of the reference committee implies a little bit of criticism for inactivity on the part of the Committee on Mental Health, I believe this word of explanation is in order. The members of the committee have bestirred themselves throughout the past year, particularly on a diplomatic level, since a great number of public issues are rather touchy ones. They have been extraordinarily touchy when Indiana officialdom other than medical has been concerned in the administration of state institutions. Important things have been discussed and have not been given formal report for good reasons, especially in view of our campaign against the socialization of medicine. The committee has been active, it has been diplomatic, it has been cautious. I wish to point out that if every group of members of our society start out on rabble-raising campaigns to create pressure for perfection in areas of public health, we will be playing into the hands of socialized medicine. We can't all of us propagandize for the immediate correction of those imperfections we see, without adding fuel to the fires that they are building in Washington for our destruction. I wish to offer this amendment to the report of the reference committee, that this additional paragraph be inserted: "The conservative and diplomatic activity of this committee is commended."

(Dr. Hahn's motion was seconded by Dr. Oliphant, and this section of the report was adopted as amended.)

(8) *Report of the Committee on School Health and Physical Education.* Your reference committee commends the members of this committee for their interests and for their attendance at many meetings related to this problem and recommends the adoption of the report as published.

(9) *Report of the Committee on Traffic Safety.* Your reference committee notes with pride the coordinated activities of this standing committee and its cooperation



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Food customs? He can describe the bill of fare in far away places some people never heard of. His personal eating habits, however, are those of most men in public life—a feast when the hectic schedule permits, just a bite here and there between times.

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with the various state agencies interested in the same problem. We recommend the adoption of the report as published.

(10) *Report of the Committee on Tuberculosis.* Your reference committee regrets the failure of the standing committee to hold any meetings during the past year. After due and careful consideration the supplemental report has been found to cover problems which are already under study by duly constituted legal agencies and the reference committee finds after consultation with authorities that a need for additional beds for the care of tuberculous patients has not been proven to the satisfaction of the majority of the members of the reference committee. Therefore, the reference committee recommends the deletion of the supplemental report.

It was suggested to the reference committee that the members of the standing committee on tuberculosis for next year study the problem of the care of the tuberculous patient and that this study be conducted by members of the Indiana State Medical Association who are not specializing in tuberculosis or in diseases of the chest, in other words, some general practitioners to study this in cooperation with these legally constituted agencies. That is a suggestion to the incoming president from this reference committee.

We recommend the adoption of the report as published in the handbook.

(11) *Report of the Committee on Venereal Disease.* Your reference committee unanimously agrees with the report and with the conclusions as published in the handbook. It has been brought to our attention that there is no universally accepted scheme of treatment for venereal diseases and that the standing committee, therefore, would be unable to make specific recommendations upon any phase of this problem at this time.

It was moved and seconded and unanimously adopted that this reference committee call attention of this particular House of Delegates that on previous occasions the Venereal Disease Committee has made recommendations that the serological service of the State Board of Health should be restricted to those individuals who are unable to pay and that no corporation should be considered indigent or eligible to receive such services at the expense of the taxpayers. Upon repeated occasions former Houses of Delegates have concurred in these recommendations.

We recommend the adoption of the report as published.

(12) *Resolution from the Bartholomew-Brown County Medical Society concerning the control of rabies in Indiana.* Your reference committee wishes to commend the members of this county medical society for their interest in this problem. We agree with the objectives outlined in the resolution but wish to call attention to the fact that the legislation which is recommended in this resolution is for practical purposes on the statute books and that the efforts of the county medical society and the Indiana State Medical Association should be centered toward the local enforcement authorities, causing them to carry out their official duties.

We move the adoption of this report of the Reference Committee on Hygiene and Public Health as a whole.

HARRY P. ROSS, M.D., Chairman
MINOR MILLER, M.D., Vice-chairman
M. I. HEWITT, M.D.
GEORGE A. MAY, M.D.
WILLIAM A. KARSELL, M.D.

MISCELLANEOUS BUSINESS

Dr. J. William Wright, chairman, presented the following report, which on motions of Dr. Wright, duly

seconded and carried, was adopted section by section and as a whole.

It becomes my duty as chairman of the Reference Committee on Miscellaneous Business to submit to you the recommendations of this committee on the reports and resolutions assigned to it, for your consideration.

1. *Report of Committee on Centennial Arrangements.* This committee wishes to commend most highly the Committee on Arrangements for the excellent program of entertainment and scientific subjects.

2. *Report of Committee on Civic Relationship and Community Health Agencies.* This is a new committee, created by our president for the purpose of coordinating the accomplishments of the various committees through their respective chairmen. This committee wishes to commend this committee of chairmen and most respectfully recommends continuation of the committee.

3. *Report of Committee on Conference of County Medical Society Officers.* The committee very highly endorses this report and recommends continuation of the conference.

4. *Report of Committee on Indiana Inter-Professional Health Council.* The committee has noted the broad scope of their interesting program and commends its activities.

5. *Report of Committee on Prepaid Medical and Hospital Insurance.* The committee agrees in principle on the considerations of the necessity for increasing the complete medical care as early as possible. It also recommends that the committee be enlarged to include a representative from each district.

6. *Report of the Committee on Veterans Affairs and Rehabilitation.* The committee approves the report and especially endorses the following resolution adopted by the Council of the Association April 10, 1949, and recommends that it be approved, reaffirmed and emphasized, and through our delegates to the A.M.A. it be introduced at the Interim Meeting in Washington, D. C., December 6 to 9, 1949.

"To the American Medical Association:

"WHEREAS: Doctors have not volunteered in sufficient numbers to meet the armed services' requirements for medical men, and

"WHEREAS: Many doctors have been educated at total or partial government expense, and

"WHEREAS: Many doctors were deferred from service in order to complete their educational requirements, and

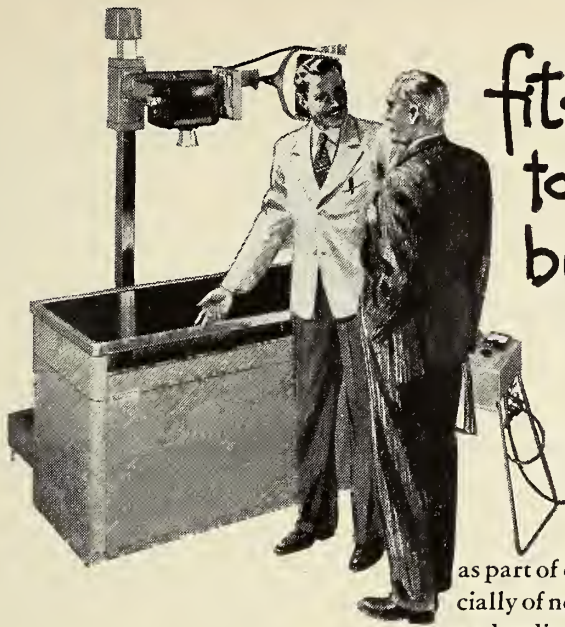
"WHEREAS: Unfavorable publicity toward the medical profession generally would be occasioned by a draft sought from other sources,

"Therefore Be It Resolved that the American Medical Association be requested to reconsider its previous stand, and take the leadership in guiding draft legislation for physicians."

7. Nominations for senior membership:

County

Allen	J. R. Adams
	E. M. Van Buskirk
	J. C. Wallace
Bartholomew-Brown	J. K. Hawes
Boone	Frank H. Riley
Cass	Milton Stewart
	Fred Terflinger
Clay	H. H. Ward
Crawford	J. J. Johnson
Elkhart	J. S. Slabaugh
Hendricks	O. H. Wisehart
Jefferson	Guy W. Hamilton
Kosciusko	Charles E. Thomas

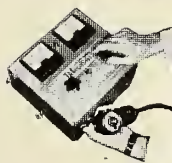


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budget, too!
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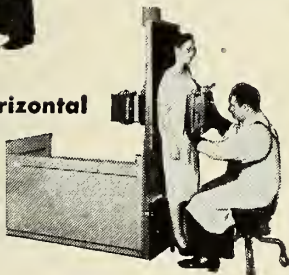
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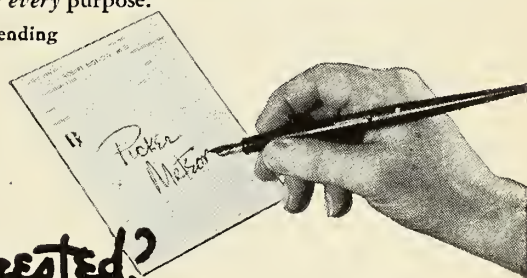


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	Henry Leonard
	Daniel J. McCarthy
	Joseph Moutoux
	Jule O. Wehrman
Morgan.....	Claude White
Putnam.....	Walter R. Hutcheson
	Everett M. Hurst
Randolph.....	George H. Davis
St. Joseph.....	William H. Hillman
Vigo.....	W. D. Asbury

Committee recommends election of entire list.

8. *Resolution creating Grievance Committee.* Section 10, Chapter VIII of the By-Laws, pertaining to the duties of a standing committee, namely Committee on Public Relations, clearly designates that committee as the one to which all grievances must be referred, and furthermore, Section 9, Chapter VIII of the By-Laws clearly defines the duties of the Council, to which all matters of a controversial nature shall be referred.

It is the opinion of the committee that the creation of a separate grievance committee would promote confusion and be repetitious, and, therefore, it disapproves. The committee does recommend, however, that on the Public Relations Committee five ex-presidents be named.

9. *Report of the Indiana A.M.A. Coordinating Committee and supplementary report.*

(See minutes of first meeting of the House of Delegates, pages 1179 and 1180.)

Your reference committee approves in principle the supplementary report, it being understood that the state association carry out a uniform program on a state-wide basis, through its agent or committee, and that the entire cost of same be assumed by the state association. And your reference committee further recommends that expenditure of funds shall be commensurate with the amount of funds available.

10. Increase in dues.

The committee, having recommended some procedures, necessarily thought that the association should be provided with some funds with which to carry it out. This resolution was given to us by the Council:

"Resolved, That the membership dues, beginning with the year 1950, shall be \$35.00 per year."

The committee recommends the adoption of the above resolution.

Discussion

MINOR MILLER, Vanderburgh County: I don't know how the rest of you feel about going back to your home communities and telling the boys you have upped their dues \$20.00. I rather think you are going to have a little trouble back there when you do it. I think that we more or less had the way pointed out to us in the way Mutual Medical was established. I don't believe from the reaction I got from different members that this \$20.00 increase is going to be too popular, and I am afraid that the secretaries are going to have a great deal of trouble collecting it if it is thrown on to them. American medicine is fighting to retain the American way, and it seems to me that we would be on much better ground if we would take this back home, talk it over with our local societies, and then come back at a later date and set the amount that our dues should be upped. I am not against paying it, and I don't think our membership will be if they are informed, but I do think they will resent this being thrust upon them by

the House of Delegates. Therefore I wish to amend that report of the committee, so that we can take it back home and come back here in December in a special meeting of the House of Delegates to consider it.

(Motion seconded by Dr. Gerald S. Young.)

CLAUDE DOLLENS, Lawrence County: I know that there is no question about the way the members in my county feel. A few of them are up here at the meeting and I know they don't want that much of a raise. Personally, I would be glad to vote for it if we have need for that much of a raise in our dues, but I do know that it isn't going to taste good when I take that back to the men in Lawrence County.

GEORGE A. MAY, Jefferson County: If we go home without voting on an increase we put it off for possibly another year. We are fighting socialized medicine, and if we don't pay to keep what we have, one of these days we are going to wake up and have nothing. Then the fellows back home are going to say to us, "What have you men been doing? If you don't do anything, what is the use of having you up there?" I think we should do something now about this increase, get busy. We are doing well now, and if we keep pressing it we will do some good. The place to do the fighting is at home. The A.M.A. does some good, but if we get at the bottom of this with the people at home we will do more good. It takes money to do it. If corporations and other businesses can spend 1 percent, surely we can spend one-half percent or more, and I don't think \$2.00 a month is going to hurt any doctor in the state of Indiana.

JAMES M. KIRTLEY, Montgomery County: In the Montgomery County Medical Society we have already had an informal poll of our members, for we knew that this thing was likely to come up, and the consensus was that we should increase the dues to any amount that would be needed, in order to do this fighting that we are going to have to do right now. I think December may be too late. There may be some other reason for putting it off at that time, and I agree that we should vote at this time on the increase of dues.

JAMES B. JOHNSON, Putnam County: Most of us know what they think about socialized medicine back home in Putnam County. With rare exceptions they are strongly against federal medicine. It seems to me that it is the American way to vote for this increase in dues, and let the majority rule.

JACK PORTER, Boone County: I represent a rural community. We took a poll; the majority of our members are opposed to the dues increase. They feel that spending \$100,000.00 a year might possibly backfire on us. They feel that such a program is not in the best of taste and might prove to be to our disadvantage.

FRANK H. NEUKAMP, Fayette-Franklin: I believe we would be in good order with our people at home if we would make some sort of statement at a future date giving our people at home an account of how the money is spent. The question is, "Where did the money go?" If isn't what it cost, it's where did it go. They are very resentful of being accused of raising a slush fund. Doctors want to know where the money went.

(At the request of the chairman Dr. Minor Miller re-stated his motion "that this House of Delegates refrain from taking action on this increase in dues at this time and return at some early date in December, after taking it home to the county societies, to consider it." This motion to amend the report was lost on voice vote.)

ALBERT M. MITCHELL, Vigo County: I am the fellow who made the motion at the Council meeting for the \$20.00 increase. I did it for a couple of reasons. The first one is that we had a voluntary assessment by the A.M.A. last year. Two-thirds of the men in the state paid it; one-third didn't. We probably won't have any more assessments by the A.M.A. I don't know, but I don't think it is right for two-thirds to pay the freight

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**Reprints on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60;
Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

for that one-third. We have a campaign coming up next year. It is going to take money in all counties to fight these Congressmen who want to put in socialized medicine. The result of my thinking on this is that instead of that one-third getting by without paying anything, they will have to pay something themselves, and I don't think it is right for the two-thirds to pay for that one-third.

CYRUS J. CLARK, Marion County: Gentlemen—There is not a carpenter, bricklayer, automobile mechanic or electrician in this country paying as little as \$15.00 a year dues to his union. For that he gets no actual benefit. He makes very much less; he lives on much lower standards by and large than you people do. Doctor Robins talked to you this noon—time is awasting. The federal government doesn't stop spending your money to fight you for any period of time. They are grinding it out good, loud and long. It seems to me that the time to act is now. I grant you that you don't want to spend any money if you don't have to, but if you will consider the interest rate that you are going to get for a \$2.00 a month payment, at the possible expense of having your income cut down to \$3,500 a year, it is tremendous. I think you should have enough confidence in your group at the table up there to know that they aren't going to spend any money that they don't feel is justifiably spent. You will not speak to your patients as you should. This is not going to take the place of your sitting down and talking to your patients individually. That is the best public relations you can get, but certainly this will be much better than nothing, or much better than an incoherent, uncoordinated attack. I am very much in favor of it. (Applause.)

11. Collection of Auxiliary Dues.

Anticipating that this House of Delegates would use the good judgment that it has, the committee recommends that this be deferred, due to the increase in dues.

J. WILLIAM WRIGHT, M.D., Chairman
WILLIAM H. GARNER, M.D., Vice-chairman
W. U. KENNEDY, M.D.
C. V. ROZELLE, M.D.
A. C. YODER, M.D.

Resolution on Draft Legislation

Following discussion by Dr. Sensenich, on motion of Dr. Nafe the House voted to reconsider this resolution which it had accepted in adopting paragraph No. 6 of the report of the Reference Committee on Miscellaneous Business. The resolution was discussed further by Drs. Daniels, Garner, C. J. Clark, Sensenich, Petronella, Glock, Elton Clarke, Nafe and May. On motion of Drs. C. J. Clark and May, the resolution was amended to include the words, "if necessary." The resolution as finally adopted therefore reads as follows:

Therefore Be It Resolved that the American Medical Association be requested to reconsider its previous stand, and take the leadership in guiding draft legislation for physicians, if necessary."

Reports of Officers

Dr. Virgil McCarty, chairman, presented the following report, which on motion of Dr. McCarthy, duly seconded and carried, was adopted as a whole:

Your reference committee on Reports of Officers met and reviewed the addresses of the president and president-elect and also examined the reports of the following officers and committees, all of which were approved by the reference committee:

1. Report of Executive Secretary
2. Report of Treasurer
3. Report of Chairman of Council
4. Reports of Councilors

5. Report of Executive Committee
6. Report of Auditing Committee
7. Report of Editor of THE JOURNAL

It is noted that the Council recommends the adoption of the following resolution: "*Resolved*, That the position of assistant treasurer be and hereby is created and that it be filled by appointment by the Council, and that the Council prescribe the duties to be performed by such officer." The committee approves this resolution, and I so move.

The president is to be complimented for his tireless efforts and extra burden of work carried during the year to plan successfully this great Centennial Celebration and meeting. His address was most informative and inspiring and reflects much credit to the physicians of Indiana in their Century of Progress.

The committee wishes to emphasize to the membership that Doctor Hauss has spent an unusual and remarkable amount of time and effort in carrying out the heavy burdens of his office. The success of this convention reflects his outstanding ability to lead and to organize.

The president-elect is to be commended for his clear vision of the problems confronting the profession at a time when powerful forces are driving us headlong toward a welfare state. His timely advice that we, as doctors, must extend our influence to political matters or face destruction should not go unheeded. The committee approves the recommendations of the president-elect with no exceptions.

These officers and committees are to be congratulated for work well done during this Centennial year.

I move adoption of this report.

VIRGIL McCARTY, M.D., Chairman
ALFRED ELLISON, M.D., Vice Chairman
MELVIN H. DENNY, M.D.
BERT ELLIS, M.D.
WILLIAM C. REED, M.D.

Resolutions of Appreciation

Dr. Maurice E. Glock presented the following resolutions, which were adopted on motion of Drs. Glock and Daniels:

"WHEREAS, this Centennial Convention of the Indiana State Medical Association is viewed by the delegate body, the general membership and guests as the finest in the history of the organization, and

"WHEREAS, this delegate body is aware of the tremendous amount of work necessary in the planning of a convention of this magnitude to assure its complete success, now

"*Therefore Be It Resolved*, that the Indianapolis Medical Society, as the host organization, its General Arrangements Committee and its Auxiliary be extended an official vote of confidence and thanks for the staging of such a completely successful centennial meeting, and that like expression of sincere appreciation be extended to Dr. Augustus P. Hauss, the retiring president, for his untiring efforts to assure the success of this Centennial Convention, and

"*Be It Further Resolved*, that this House of Delegates extend its official thanks to *The Indianapolis Star*, *Indianapolis News*, *Indianapolis Times*, the Associated Press, United Press, International News Service and the various radio stations for their splendid coverage and promotion of this Centennial Meeting.

THE PRESIDENT: You know, when you are 61 years old, you sometimes get a little emotional. You feel like crying when you are happy, and a lump gets into your throat which prevents you from saying the things that are within your heart. Why you do this, I do not know, but you do, especially if it pertains to something you love. I love this Indiana State Medical Association.

I am trying my best to say to you that in this great



During Pregnancy...

VITAMIN REQUIREMENTS ARE INCREASED

Vitamin deficiency may occur as a result of increased requirements during pregnancy, febrile conditions, hyperthyroidism, or other conditions in which the metabolism is greatly augmented.

The vitamin deficiencies most commonly seen are those of the B complex. Since deficiency of only a single vitamin of this group rarely occurs, and since many of the metabolic functions of

members of the vitamin B complex are closely related, best results are obtained in most cases by administering *all* of the B complex vitamins known to be of importance in human nutrition. This can be done most conveniently by prescribing a sufficiently potent preparation containing these vitamins combined in properly balanced proportion.

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Patronize Your Advertisers

Centennial Year the Indiana State Medical Association (not its officers, but its men), its county medical societies, its committees, and this House of Delegates, have made history, history that has never been made before, progress that has never been made before, a progress that extends a beacon light far into the new century of Indiana medicine.

I commend the sincere and courageous actions of this House of Delegates, and I am very grateful for your loyal cooperation.

Thank you, and may God bless this great state medical association.

No further business appearing, the House adjourned sine die.

EXECUTIVE COMMITTEE

September 25, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; A. P. Hauss, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.

A. F. Weyerbacher, M.D., treasurer; Frank B. Ramsey, M.D., editor of THE JOURNAL; Albert Stump, attorney; Ray E. Smith and J. A. Waggener.

Guests: Lester D. Bibler, M.D., president, and Norman R. Booher, M.D., secretary-treasurer, Indiana Academy of General Practice; John D. VanNuys, M.D., and Clyde G. Culbertson, M.D.

1949 Annual Session, Indianapolis, Sept. 26-29, 1949

The address of the president, to be given over radio station hook-up during the broadcast of the Baltimore & Ohio glee club program, Tuesday evening, September 27, was approved.

Legislative Matters

National:

On motion of Drs. Portteus and Ellison, the committee voted to contribute \$100 to the National Society for Medical Research for the year 1949-1950.

Local:

On motion of Drs. Portteus and Black it was decided to request the Council to rescind its previous action authorizing introduction of a bill in the 1951 General Assembly to make payment of rebates illegal.

Letter read from the secretary of the Noble County Medical Society protesting the new state law which requires physicians to report to the State Board of Health the name of every person diagnosed as blind or having a visual impairment to a degree to interfere with his normal ability to earn a livelihood.

The adjutant of the Paul Coble Post of the American Legion gave a report on the efforts of chiropractors to place the national American Legion on record as favoring employment of chiropractors on the medical staff of the Veterans Administration.

Indiana A.M.A. Campaign Coordinating Committee

A proposed radio and advertising program was outlined by the field secretary, after which it was taken by consent that the chairman of the committee should present the proposition to the Council.

Statements of receipts and expenditures for August for the association and THE JOURNAL were approved.

Organization Matters

Training of technicians. After a discussion on the proposal of the Indiana Academy of General Practice that Indiana University School of Medicine establish a short course for training girls to do simple laboratory procedures, motion was made by Drs. Black and Portteus that a committee be appointed to make further study of the problem, this committee to consist of:

1. Two members to be appointed from the Indiana State Medical Association.

2. Two members to be appointed by the Indiana Academy of General Practice.

3. Two members from the Indiana Association of Pathologists.

4. Two representatives from the Indiana University School of Medicine, to be selected by the dean of the Medical School.

A letter of protest against the suggestion from Miss Rachel Lehman, instructor in Medical Technology, Indiana University Medical Center, was read during the discussion.

The following resolution, received from Henry W. Heine, executive secretary of the Indiana Pharmaceutical Association, was read:

"WHEREAS, it has been reported to the AMERICAN PHARMACEUTICAL ASSOCIATION that pharmacies established in certain clinics are being operated as part of the physician-owned clinic service and that this may lead to coded prescriptions, monopolistic practices and deterioration of the pharmaceutical service supplied, be it

"Resolved, that the AMERICAN PHARMACEUTICAL ASSOCIATION express its disapproval of this trend and request organized medicine to exert its influence in curtailing such developments."

Dues and assessments of other state medical associations. Presentation of a report on the amount of dues and assessments of other state medical associations was recommended on motion of Drs. Ellison and Portteus.

American Public Health Association meeting, New York, October 24-29, 1949. Letter was read from the assistant secretary of the Council on Medical Service of the American Medical Association urging attendance of the executive secretary at the forthcoming meeting of the American Public Health Association in New York City in order that he might participate in the program of the new Medical Care Section.

Two signatures on association checks. It was taken by consent that the Executive Committee recommend to the Council that the By-Laws be changed to legalize two-signature checks.

Magazine subscription proposal. Proposal that magazines be offered to members through the columns of THE JOURNAL, with the commission going to the medical and nursing school scholarship funds, was rejected on motion of Drs. Ellison and Portteus.

Request of E. M. Dill, administrator, Department of Public Welfare, for a conference with the Executive Committee at its next meeting was approved.

Invitation to meeting of Indiana State Chamber of Commerce. Consent was given for someone from the headquarters staff to attend the meeting at French Lick beginning Friday, October 21, of the Indiana State Chamber of Commerce.

School and Community Health Workshop. Letter from Dean W. W. Patty, of the School of Health, Physical Education, and Recreation of Indiana University, thanking the association for its contribution to the 1949 School and Community Health Workshop was read.

THE JOURNAL

Report on advertising:

Increases to September 25, 1949-----\$ 694.00
No decreases -----

Total increase for month-----\$ 694.00
Total increase for year-----\$4,281.85

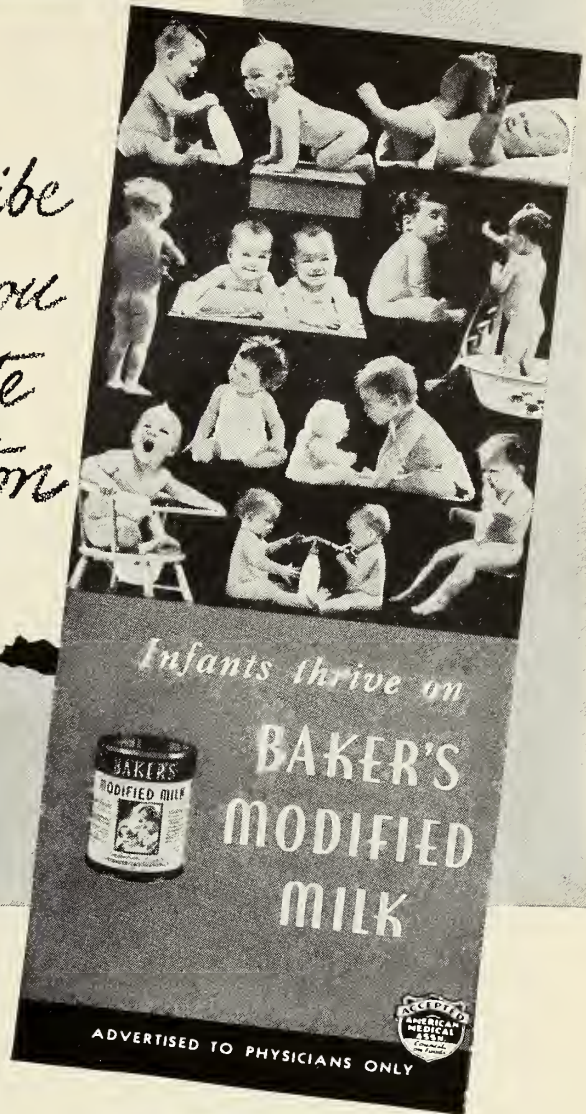
On motion of Drs. Ellison and Portteus, approval was given for the editorial secretary to attend the Secretaries-Editors Conference in Chicago, November 3 and 4, 1949.

There being no further business, the Executive Committee adjourned to meet again at 10:00 a.m., Sunday, October 30, 1949, at the Columbia Club.

*Dear Doctor,
If you prescribe
infant feeding you
will appreciate
this information*

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6. Added iron.
7. Zero curd tension.



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THE BAKER LABORATORIES INC., Cleveland, Ohio

Division Offices: San Francisco, Los Angeles,
Denver, Seattle and Greensboro, N. C.



COMMITTEE ON PUBLICITY

August 19, 1949

Present: James O. Ritchey, M.D., chairman; Walter L. Porteus, M.D., a member of the Executive Committee who was a guest, and Ray E. Smith, executive secretary.

A news release by the Committee on Medical and Nursing School Scholarships about awards to an Indianapolis and a LaGrange boy was approved.

A release for local newspapers about the I.S.M.A. exhibit at the Indiana State Fair, submitted by the Committee on State Fair, was approved.

A release on physicians who will receive the fifty year award this year was approved.

The committee discussed the taking of blood pressure readings at the state fair and questioned the advisability of continuing this practice.

The following "Hints on Health" releases were approved:

Week of September 26, 1949—"The Human Brain."

Week of October 3, 1949—"Viruses."

Week of October 10, 1949—"Leg Ache."

Speakers were procured for the following meetings:

August 31, 1949—P.T.A. Council, Greendale, Indiana. Executive secretary will speak on "Pills and Politics."

October 8, 1949—Alumni of Indiana University School of Dentistry, Bloomington. Executive secretary will speak on "What's Ahead for Dentistry and Medicine."

September 2, 1949

Present: Homer G. Hamer, M.D., who presided; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; James A. Waggener, field secretary, and Ray E. Smith, executive secretary.

The following "Hints on Health" releases were approved:

Week of October 17, 1949—"The Knee Joint."

Week of October 24, 1949—"Deformities."

Week of October 31, 1949—"Superfluous Hair."

Week of November 7, 1949—"The Menopause."

A news release, prepared by the Committee on Diabetes, was approved.

The committee approved for submission to *The Indianapolis Star* for the special medical section on September 26, 1949, an article, "Surgery with Poisoned Arrows," received from the American Society of Anesthesiologists.

Nine news releases on the Centennial Convention were approved.

Pictures and names of physicians appearing in the August issue of the *Monthly Bulletin* of the Indiana State Board of Health were decided as not objectionable, but the committee held that use of names and pictures of practicing physicians is not good as a matter of policy.

A "Statement of Policy" by the Madison County Medical Society was recommended for publication in *THE JOURNAL*.

September 16, 1949

Present: James O. Ritchie, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

A "Hints on Health" column for release the week of November 14, 1949, entitled "The Common Cold," was approved.

A release on historic and scientific exhibits at the 100th annual convention of the Indiana State Medical Association was approved.

Requests of Miss Catherine Daniels of Radio Station WISH, Indianapolis, for the president of the association to be interviewed on her program at 1:00 p.m., Tuesday, September 27, 1949, was approved upon the condition that acceptable script would be submitted to the committee.

The field secretary reported receipt of three radio scripts of thirteen minutes each from Whitaker and Baxter. The committee directed him to procure copies for each county medical society.

The committee approved copy of a half page advertisement in connection with the centennial convention which will appear in the three Indianapolis dailies.

COUNCILOR DISTRICT MEETINGS

SEVENTH DISTRICT

The fall meeting of the Seventh District Medical Society was held October 12, 1949, at the Highland Golf and Country Club in Indianapolis, with Dr. Horace M. Banks, president, presiding.

The Seventh District voted officially to endorse the action of the House of Delegates of the Indiana State Medical Association which increased the dues to \$35.00.

Elections resulted in the following new officers: Dr. Edward Pitkin, of Martinsville, president-elect; Dr. Ralph V. Everly, of Indianapolis, secretary-treasurer; Dr. Donald E. Wood, of Indianapolis, was elected alternate councilor to the state association.

A resolution opposing compulsory health insurance was ordered sent to President Truman, to the two U. S. senators from Indiana, and to the various congressional representatives from the state.

The meeting closed with a dinner in the evening for 90 physicians, their wives and guests. Mr. Wilbur Shaw, president of the Indianapolis Motor Speedway, was the guest speaker.

TENTH DISTRICT

One hundred forty-two doctors and their wives attended the fall meeting of the Tenth District Medical Society, which was held at Gary on October 11. The guest speaker was Dr. Paul R. Hawley, chief executive officer of Blue Cross—Blue Shield Commissions, who discussed the threat of socialized medicine and outlined a program for the doctors to follow in waging their attack. Doctor Hawley emphasized the need for physicians to correct alleged deficiencies in the profession and to promote voluntary health insurance, which represents the best defense against government health insurance.

Elections resulted in the following officers for 1950: president, Dr. C. W. Yarrington, Gary; secretary, Dr. D. B. Templin, Gary; alternate councilor to the state association, J. Robert Doty, Gary.

Dr. William H. Howard, of Hammond, councilor, explained the association's proposed campaign of public education, as did Mr. J. A. Waggener, field secretary of the state association.

ELEVENTH DISTRICT

The Carroll County Medical Society served as host for the eighty-second, semi-annual meeting of the Eleventh Indiana Councilor District, Wednesday, September 21, at Delphi. Marion was selected as the location for the spring meeting.

F. M. Whisler, M.D., Wabash, president of the district, called attention to the fact that doctors must remove their apathy on the subject of socialized medicine.

THROAT SPECIALISTS REPORT ON 30-DAY TEST OF CAMEL SMOKERS—

**"Not one single case of throat
irritation *due to smoking* CAMELS!"**



YES, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast-to-coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!



According to a Nationwide survey:

**MORE DOCTORS
SMOKE CAMELS**
than any other cigarette!

Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

Patronize Your Advertisers

A paper on the "Differential Diagnosis of Lesions of the Knee with Negative X-rays," was presented by James R. Stack, M.D., Associate Professor of Bone and Joint Surgery, Northwestern University, Chicago.

Brice E. Fitzgerald, M.D., Logansport, presented a paper on "Neoplasms of the Head and Neck."

A paper on the "Uses and Abuses of the Antibiotics," was given by R. A. Solomon, M.D., of Indianapolis.

Following the dinner, members in attendance were told of the activity in the district in behalf of Charles C. Crampton, M.D., Delphi, who has practiced medicine for fifty-six years, for the "General Practitioner of the Year" award. Dr. George E. Davis, director of the Office of Student Affairs, Purdue University, gave several readings of James Whitcomb Riley's works.

The Auxiliary to the Carroll County Medical Society with Mrs. Herbert Gros, Delphi, as President, entertained the ladies at the American Legion Home. An especially good program was arranged.

LOCAL SOCIETY REPORTS

Clinton County Medical Society members met at Frankfort on September 6, when the thirteen members and five guests present heard Dr. John M. Young, of Indianapolis, speak on "Surgical Measures for Relief of Prostatic Obstruction."

Greene County Medical Society members held a meeting at the Freeman Greene County Hospital, in Linton, on September 15. This was a business meeting, and fifteen members were present.

Hendricks County Medical Society members met at Avon on August 10. The nine members present heard Dr. A. B. Richter, of Indianapolis, speak on "Recent Advances in the Treatment of Heart Disease."

Another meeting was held on September 13, when Dr. Don D. Bowers, of Indianapolis, was the guest speaker. His subject was "Office Gynecology." Eight members and eight auxiliary members were present.

Howard County Medical Society members held a meeting in Kokomo, on September 2. Twenty-seven members were present to view a sound film on "Kidney Functions in Health."

LaPorte County Medical Society members held a meeting on September 15 in Michigan City. Dr. R. L. Sensenich, of South Bend, was the guest speaker. His subject was "National Health." Thirty-six members were present.

Madison County Medical Society members met at the Anderson Country Club, in Anderson, on September 19. Dr. Loren Shafer, of Wayne University, Detroit, spoke on "Penicillin in the Treatment of Syphilis." Forty-four members were present.

Warrick County Medical Society members met in Boonville on September 22. Twelve members were present to hear a representative of Blue Cross speak on community subscription.

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

MONTHLY REPORT—JULY, 1949

Diseases	July 1949	June 1949	May 1949	July 1948	July 1947
Brucellosis	5	6	2	5	7
Chickenpox	30	94	196	48	27
Diphtheria	32	19	16	18	10
Encephalitis	5	2	5	3	0
Erysipelas	3	1	4	0	1
Food Poisoning	10	1	1	2	0
Impetigo	3	0	3	18	3
Influenza	13	2	0	3	3
Malaria	1	0	1	1	8
Measles	169	545	596	230	156
Meningitis:					
Meningococcic	2	3	2	3	--
Pneumococcic	2	1	1	0	--
Unclassified	2	3	4	7	1
Mumps	65	99	173	69	22
Pneumonia	10	16	16	21	12
Polio—All Forms	252	10	2	43	8
Rabies, Animal	69	62	94	82	--
Rheumatic Fever	1	1	4	2	0
Rocky Mt. Sp. fever	4	2	2	2	5
Rubella	10	107	425	10	0
Scarlet Fever	25	59	132	41	58
Septic Sore Throat	8	0	9	5	9
Tetanus	2	2	1	2	0
Pulmonary T. B.	204	181	208	315	191
T. B., Other Forms	18	15	11	13	9
Typhoid Fever	8	4	3	10	8
Whooping Cough	116	81	47	45	220
Trichinosis	1	0	0	1	0
Bacillary Dysentery	2	0	0	0	1

MONTHLY REPORT—AUGUST 1949

Disease	Aug. 1949	July 1949	June 1949	Aug. 1948	Aug. 1947
Brucellosis	5	5	6	5	6
Chickenpox	11	30	94	5	32
Diphtheria	39	32	19	11	11
Dysentery, unclassified	1	0	0	3	0
Encephalitis	3	5	2	2	1
Food Poisoning	2	7	1	3	2
Shigellosis	2	1	0	0	0
Influenza	37	13	2	2	1
Malaria	2	1	0	3	1
Measles	39	167	545	25	48
Meningitis:					
Unclassified	2	0	3	3	7
Meningococcic	1	2	3	1	3
Pneumococcic	1	2	1	0	0
Streptococcic	1	0	0	0	0
Mumps	14	65	99	27	10
Paratyphoid fever	1	0	0	1	4
Pneumonia	38	10	16	10	15
Poliomyelitis:					
Paralytic	130	128	8	58	26
Nonparalytic	70	54	2	12	33
Unspecified	150	74	0	4	0
TOTAL	350	252	10	74	59
Rabies in animals	47	69	62	60	--
Rheumatic fever	1	1	1	1	1
Rubella	2	10	107	4	2
Scarlet fever	20	25	59	33	48
Septic Sore Throat	30	8	0	1	7
Tuberculosis:					
Pulmonary	168	204	181	189	253
Other forms	15	18	15	13	7
Typhoid fever	4	8	4	5	28
Whooping cough	66	116	81	43	252

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

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DECEMBER, 1949

NUMBER 12

THE GENERAL PRINCIPLES OF PSYCHOTHERAPY IN GENERAL PRACTICE*

EDWARD C. BILLINGS, M.D.

DENVER, COLORADO

The Author:

Dr. Billings received a B.S. degree in 1926, an M.D. degree in 1928, and an M.D. *cum laude* in 1929 from the Indiana University. Following his internship at the Indiana University Medical Center he continued as Chief Resident in Medicine for two years, then went to the Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital. During the war he served as consultant in neuropsychiatry and internal medicine for the South Pacific area. He is a diplomate of the American Board of Psychiatry and Neurology and of the American Board of Internal Medicine.



TO many distinguished deceased and present members of the Indiana State Medical Association I am indeed indebted. It was here in Indianapolis, some twenty years ago, that I was honored with the privilege of receiving counsel and discipline in clinical medical practice and investigation from many of you gentlemen present here today. To you I again wish to express my deep appreciation. To those departed members of this association, Dr. Charles P. Emerson, Dr. Frank H. Hutchins, Dr. Albert Sterne, to mention but a few of the masters and men of vision who gave so freely of their time and wisdom, I owe my interest

in psychiatric medicine. It was therefore with a feeling of having been honored greatly, and I might also say with a personal sense of considerable responsibility, that I accepted your invitation to return to Indianapolis to talk of the general principles of psychotherapy in the general practice of medicine. I hope that within a measure I may do you, my teachers, justice.

The practice of medicine has changed much. Nevertheless, there is one aspect about it that has not been and will not be altered. That is the matter of the partnership between the patient, seeking information and assistance, and the physician, equipped by training and experience, who furnishes it. Years ago very often the patient, aware only of his distress and having no understanding

* Presented at the Centennial Convention of the Indiana State Medical Association, Indianapolis, September 27, 1949.

of its origin and its meaning, stood inarticulately by while the doctor examined him and prescribed. In that era the doctor seldom imparted any information about the disorder to the patient. Both were essentially uncommunicative and therefore neither knew much about the other. It was an association or partnership with but a modicum of sharing. In those older days the patient yielded everything to the doctor, while the latter, not from selfishness but rather out of regard for his limited knowledge of the facts of personality functioning, often felt reluctant to give freely of his learning.

Today the situation is different because the value of collaboration has been proved and accepted. As a result of education directed toward the improvement of the health and efficiency of our populace, people know more about physical and psychological medical matters than they ever knew before. Today, in this world of speed and competitiveness, the patient is becoming more acutely aware of his need to maintain greater and more comfortable efficiency in the management of his personal business of living. Facts pertaining thereto, that is, those with which psychiatry must deal, are in the main more easily grasped by people in general than are the data of anatomy, physiology, tissue pathology, biochemistry, et cetera. Because of this people have come more and more to expect their doctors to be psychosomatically oriented and to give attention, without embarrassment or hedging, to their personal functions as well as their more somatic ones. The prevention of major psychiatric illness through diagnosis and common-sense treatment of disorders of personality, which today cause more noneffectiveness than all the somatic illness combined, is the responsibility of the general physician, who is the one, second only to the patient, to become aware that a complaint problem exists.

PERSONALITY DISORDERS

Before taking up the matter of medical psychiatric treatment, it perhaps is apropos to review briefly our concepts of the meaning of personality disorders. To begin with, it is essential that we recognize that symptoms and signs of illness, whether it be primarily somatic or psychiatric in nature, are but manifestations of the patient attempting to attain or maintain healthy efficiency by overcoming or compensating for some disorder in functioning as caused by an invading organism, some structural or functional variation, or by a life situation. Then a personality disorder, like a physical one, is but the manifestation of an individual attempting, without knowing why or how, to make an adequate adjustment, to be efficient as a functioning organism and to live satisfactorily as long as possible.

It may be that the given individual is reacting and behaving in an abnormal way, exhibiting local bodily or general functional disturbances and complaining of symptoms because his body chemistry or particular tissues are primarily at fault, or that

involving organisms or exogenous toxins and physical forces are exercising an effect. If he is not in this sense primarily sick in a physical way, then he may be sick in an "all over way" as a personality because:

1. He is fundamentally unable to surmount the business of meeting life as he finds it, due to:

(a) intellectual inadequacies—in this case the reaction is termed one of **INTELLECTUAL INADEQUACY**
and/or

(b) a poor balance and integration of potentially competent functions as in **IMMATURITY OR CONSTITUTIONAL PSYCHOPATHIC DISORDERS**.

2. Trauma or disease has destroyed or changed central nervous system structures, the chief function of which is that of integrating all functions. Diagnostically, the resultant reaction is termed an **ORGANIC** one.

3. Toxic and infectious factors have changed the functional support of the central nervous system. The reactions occurring on this basis are termed **"SUPPORT" OR DELIRIOUS ONES**.

4. Throughout a lifetime there have been developed variations in the symbolizing functions, especially as they relate to the thinking activities, that give rise to queer, odd and often incongruous total actions and reactions, diagnostically described as **SCHIZOPHRENIC, PARANOID AND PARANOID** conditions.

5. Of constitutionally determined variations in, or other disorders of, the personality-regulating functions, especially those of mood or affect. Such disorders are called the **AFFECTIVE REACTIONS**, i.e., depressions or elations.

6. Owing to the particular make-up, training, experiences, et cetera, of the individual, he has difficulty in using adequately and in disposing of previous experiences and memories, anticipations, conflicts, and such *nonmental* inadequacies and peculiarities as fatigability, sensitivity to special topics and circumstances, biological rhythms in sleep, weight gain or loss, sex urges; and, therefore, is poorly equipped to meet the complexities of life. In these instances such a person reacts sooner with variations in functions and the concomitant symptoms to lighter burdens and less weighty factors than does the average person. The resulting reactions are considered as being **MINOR DISORDERS OF PERSONALITY OR THE PSYCHONEUROSES**.

TREATMENT GOAL

Before turning to the principal theme of this discussion, therapy, it might be apropos to mention what we expect of treatment. Frequently the question is asked, "Are psychiatrically ill people really cured by treatment?" In the sense that the physician alone does something or other to the patient, such as an appendectomy, and the patient is for-

ever relieved of the problem, the answer is, "No." Treatment in the case of the psychiatric patient is more on the order of that of the diabetic, wherein, through substitutive ministrations and through the constant cooperation of the patient, he is given understanding of the complex factors at play and their management, and is taught more effective means of operating his life. Thereby he is rendered symptom-free, comfortable and relatively effective. He is not healed of diabetes, but is restored to more effective living. So it is with the emotionally sick patient.

PSYCHOTHERAPY

In the field of general medicine, the institution of psychotherapy (i.e., the modification of the patient's reaction and adjustment capacities for the better, by whatever means are available) includes: First, the determination of whether a major reaction or psychosis is presented by the patient. If such a disorder is in evidence, then it is essentially a matter of referring the patient to a proper treatment center or to especially trained members of the profession. Second, psychotherapy must, by necessity, include floating temporarily without regression the more seriously ill until facilities are available for the patient's proper care or until the patient and family can accept special treatment. And, third, it includes treating in a definitive way that very large number of early or potentially psychiatrically sick individuals that make up such a large percentage of one's practice, as a phase of internal medicine. In the latter, I reiterate, lies the answer to mental hygiene.

Doing this depends on the doctor's having a knowledge of people. This is predicated on a reasonable understanding of personality development and functioning, appreciation of the racial, community and family ideologies at play in the case, and comprehension of the socio-economic factors existent. Differential diagnosis is of course important, but in the end no one can treat a mere illness. It is always a matter of treating a person manifesting an illness. Therefore the physician should be less concerned with making a technically accurate psychiatric diagnosis than with gaining a feeling of understanding of why the patient is sick. The practical application of common sense, after all, is truly science, despite the fact it cannot be encased in a syringe.

Another prerequisite for the institution of psychotherapy is the development of a clinical discipline which enables the doctor to attain and maintain a comfortable working relationship with his patient through kindness, sympathetic understanding of human nature and willingness to spend time. The adherence to a mere doctrine or formula of procedures is no substitute. The doctor must realize that his own behavior and attitude may enhance or deter his therapy. Severity and hard-boiled procedures seldom work satisfactorily. Becoming irritated or angry only leads to defective medical

judgment and too often to the subsequent loss of a patient. Taking the attitude that the patient could do otherwise or could be effective if he but would is unfair to the average psychiatric patient and is hindering to treatment. It is but human nature to project one's own unhappiness, discontent, wishful thinking and hopes onto others and it frequently occurs in the doctor-patient situation unless the doctor is ever on the alert. When it happens the patient's illness is often made worse or subsequent treatment interfered with.

On the other hand, helpful attitudes are: realization that personal problems are complex, have causes, can be understood and often corrected; sticking to facts and avoiding making apologies and excuses to the patient; the willingness to say, "I don't know"; within reason "practicing what one preaches" insofar as the general rules of living are concerned; realization that the basis of any treatment is the understanding of the nature of the disorder; and, that treatment is the strategic application of common sense, intuition and medical science.

EXAMINATION

Under the second prerequisite for psychotherapy mentioned, namely, the possession of a clinical discipline, should be included the ability to conduct an orderly and purposeful examination. *Examination in this field of medicine is treatment.* It is a collection of facts such as life incidents, relationships of events and reactions, the patient's behavior during the examination procedure, et cetera, in a way conducive to both the physician and patient comprehending enough of the factors at work and opportunities for improving the patient's living to create at least an interest on the part of the subject in finding a better adjustment. By virtue of telling his story the patient "gets something off his chest," can vent his spleen and release pent-up tensions, and is thereby relieved to some extent. In addition, through verbalization, he objectifies facts and may gain a new perspective and solve some of his own problems—a procedure we use every day among ourselves in the doctors' lounge rooms of hospitals as we ponder our trying problems. Also as a result of the examination the patient may, through emotional catharsis, desensitize himself of certain conflicts, attitudes of others, and presenting situations.

An examination affords the physician opportunities to correlate for the patient emotional conflicts, reactions, symptoms and medical facts; evaluate the significance of all of these; reassure the patient and help him with plans for the circumvention of disturbing situations; help him change his attitude to unmodifiable circumstances and thus aid him, through knowledge and practical trial, to regain security in himself and his body.

In addition to what has been said of the importance of the examination procedure as a direct therapeutic tool, it allows the physician an opportunity to attain a clear perspective as to the goals

of treatment. Is the goal a matter of merely alleviating the patient's complaint, of satisfying him temporarily, of satisfying society, satisfying the doctor, or a combination of any or all of these? On the basis of the examination, the patient may be able to formulate his illness in a new and more constructive light and the doctor is in a position to give his understanding of the patient's problems, explain the patient's responsibilities, the doctor's prerogatives, et cetera. Thus, the patient and doctor find a common ground of understanding. The patient has found some security in one who understands and he has been rendered susceptible to suggestion, persuasion and further education in the business of living.

CONDUCT OF TREATMENT

As the physician explains his impressions as to the nature of the patient's illness and what can be done about it, all based on the examination discussed and the data evolved by thorough physical, neurological and indicated laboratory studies, he should include as much as is deemed wise in the given case the following:

1. An explanation to the patient of his illness—using as much as possible the available facts in the patient's own words;
2. Desensitizing him to any feeling of shame regarding emotional illness and any factors that hinder the patient gaining insight or that thwart his progress;
3. Evaluation of the patient's assets and liabilities and dynamic situational factors that are usable, tangible and workable in order to prevent the patient from becoming discouraged at the start;
4. Prognosis (this is difficult and formidable, therefore honesty tempered with facts and common sense is better than "rules of thumb," emotional fervor and wishful thinking) which should include:
 - a. Transmission of the facts to the responsible relatives
 - b. Reassurance to the patient

Unstinted in cases of	{	Major reactions, especially depressions, anxious, fear and confusional states
Cautiously in cases of	{	Minor reactions, except acute anxiety states and in patients showing much positive suggestibility
 - c. Responsibilities of the patient, especially in abstaining from interfering activities.
 - d. Time factor—

Rule—do not set a fixed time for recovery—keep on basis of "shortest possible time."
 - e. Explanation of variations and phases in the manifestations of the illness.
 - f. Sensitize the patient to the fact that intercurrent problems and illness may arise.

5. Explanation of the physician's right to vary treatment.

6. Formulation and evaluation of the relative significance of indirect therapies—emphasizing the importance of some sort of personality analysis.

7. Arrangement for therapeutic meetings in advance.

The physician with a personality problem at hand, and having created a common ground of confidence and understanding between himself and the patient, must then marshal all resources and direct his procedure in a well regulated fashion.

In order to adjust my own attitudes to determine what roles I shall have to take as a therapist, and to keep my patient and his family oriented as to what their responsibilities are in the treatment procedure, I find it essential to lay my treatment plan in some sort of a flexible frame. The following has so far proved practical.

- I. *Indirect Therapies* or those measures used in managing and correcting the manifestations of the disorder to the extent of enabling the patient to function on as high a level of efficiency as possible, and to mobilize his resources for participation in the more direct procedure.
 1. Symptomatic or palliative measures (including the use of suggestion) for the temporary amelioration and control of the more anatomic-physiologic manifestations of the disorder.
 2. Supportive measures for the control of the more biologic and metabolic concomitants of the disorder.
 3. Sublimative measures for the utilization of the patient's interests and capacities in bringing about a better balance in living even when sick and to create greater opportunities for the institution of direct therapeutic measures.

To say more about these indirect procedures of treatment would be superfluous for they are the therapeutic measures utilized daily in improving the functional status of any sick person whether he be classified medical, surgical or psychiatric.

II. *Direct Therapies* or those measures used in managing and correcting the etiologic factors in the disorder.

1. Management of the dynamic factors in the external milieu—especially by attainment of the collaboration and cooperation of the patient's family.

The marshalling and application of any influencing focus or dynamics by the therapist depend on what is to be expected of treatment, in the light of the potentialities of the patient and his environment, and on what the physician is permitted to do if he is able. Perhaps the problem is only that of giving the patient temporary respite during which the individual can regather himself. Thus, in this instance, mere removal from the given

environment might suffice. In another instance, the improvement of the patient's adjustment and efficiency may require psychotherapy's being applied to a second person or even a family group and not at all to the initial complainant. In some few instances the therapist may devote his entire effort to the patient—and to all intents and purposes work little or none at all with the environment, and other individuals in it.

The patient and those constituting his society, through ignorance, certain beliefs, various rigidities, unwillingness to make concessions or to place confidence in others, may cause a situation to exist which, through the knowledge, diplomacy and experientially determined skill of the doctor, must be corrected before the patient can be truly helped.

2. Management of the more personality-determined factors (internal milieu) by the physician acting as a guide, counselor, and collaborator to the patient as the latter develops understanding and improved performance and adjustment capacities.

A. *Suppressive, fortifying, and balancing procedures.*

- (1) Directive and suggestive measures, including:

- (a) explanation, reassurance, and persuasion

- (b) indirect suggestion

(c) direct suggestion	{	in waking
		state
		in hypnosis
		in drug hypnosis

- (2) Physico-chemical measures, including:

- (c) Convulsive and coma-inducing procedures

- (3) Neurosurgical procedures

B. *Expressive, integration stimulating and saturation encouraging procedures:*

In these the patient assumes greater responsibility than in 2A (i.e., the suppressive, fortifying and balancing procedures) in the collaborative treatment program. Herein the communicative and intellectual assets of the collaborators are particularly depended upon to bring about a more comfortable emotional adjustment and growth, improved senses of values, attitudes more compatible with reality, and more reliable patterns of action and reaction (implicit and overt).

As I have indicated, the very crux of the successful treatment of the psychiatrically ill patient is the management of the factors within the person himself that are etiologically significant in the development of his disability. Consequently it is apparent that therapy is always a combination of all the procedures that I have outlined, in which either suppressive or expressive procedure is, in

the main, the leading theme. This depends on the degree of the person's personality organization or disorganization, the chronological and maturation age of the individual,¹ the nature and degree of severity of the presenting problem, its genesis and the knowledge and experience of the physician.

SUGGESTION

In accomplishing the *suppressing, fortifying, and balancing procedures*, the important activating or dynamizing force utilized in giving the patient confidence and security in himself and returning him to some level of acceptable and constructive adjustment is *suggestion*,—a tool used by every physician every day in caring for his every patient. The application of suggestion is enhanced by the respect the patient has for the doctor, the exemplary role that the therapist can assume, and the emotional contact between the physician and the patient. In addition to suggestion it may be necessary to utilize hypnosis or shock, coma and narcosis-producing procedures to eliminate interfering and leading effects and embarrassment reactions, to fragment set beliefs and conclusions, to activate basic instinctual drives or guide the subject through or around psychological barriers to the extent that some common ground of collaboration between the physician and patient can be attained. Explanation, suggestion, persuasion, et cetera, are utilized to:

1. Give the patient secondary security via an understanding of the meaning of his complaints and illness as a whole—at least to reassure him as far as possible as to the benignity of the complaints insofar as his future existence is concerned.
2. Attain superficial clarification of interfering and biased attitudes and hampering sentiments.
3. Dehighlight emotionally highly charged experiences, making further repression of them possible—thus increasing the patient's spontaneity and willingness to take a chance in indulging in a broader performance in the hope that the dividends in the way of gratification will be sufficient to promote continued constructive activity with or without some symptoms.
4. Re-establish a reasonable and more comfortable balance in rest, recreation, and work and to
5. Aid the patient in attaining the status wherein he can use the recurrence of symptoms as indicators as to his relative position in the state of adjustment—though actually he is still "flying blind," as it were.

Thus the therapist directs his available forces primarily at balancing the patient's basic action tendencies or conative processes and strengthening his emotional controls, with less emphasis on utilizing the subject's intellectual functions to the end of his attaining *real* insight or a full understanding with all of the personality readjustments concomitant therewith.

ANALYSIS

Direct therapy, in which *integration-stimulating and personality growth or maturation-encouraging procedures* are employed, is applicable to *some extent* in most psychiatrically ill patients. Except for a very few special children and adolescents, and only a rare individual over fifty-five years of age, patients falling into these age groups are as a rule treated better by emphasizing less personality analysis and synthesis as alluded to here. In general, the applicability of this aspect of therapy depends on the subject having average or better intelligence, cognitive attributes that allow for a fair degree of participation in analysis and synthesis, perseverance without the inclination to indulge in "to the last fact" type of analysis, and a potentially reasonable degree of organization in terms of maturity or balance in his basic functions for his period in life.

Patients showing the following reactions frequently require the utilization of this more thoroughgoing or intensive type of therapy, provided they have credible capabilities to participate:—varying degrees of immaturity reactions (constitutional psychopathy), the more chronic and deep psychoneurotic disorders, reactive affective disturbances, some of the paranoid reactions and many of the personality maladjustments in which so-called somatization reactions are prominent.

In this phase of therapy many techniques are employable, depending essentially on the patient's particular bent and ability to assume his share of responsibility in taking the lead without getting lost, and on the physician's personal makeup and ability. These techniques, which may be used singly, but usually in combination, assist in giving the patient understanding and applicable insight, include: across-the-table discussions, more or less directed by the doctor and framed in the history of the person, written personality study with concurrent discussions, so-called nondirective ventilation by the patient, creation of situations in which special or traumatic experiences can be relived and abreacted with benefit, analysis of personality performance in relation to situations of the recent past and present, analysis and control of the attitudinal and affective relations of the patient and physician, free association techniques, occasionally dream analysis if it can be practically applied to the understanding of the present and future behavior of the patient. At times in special hospitals or particular types of practice, the above can be augmented by group psychotherapy of one sort or another.

So by the application of *education* as defined and as a dynamic treatment process, utilized in the framework of the whole therapeutic methodology as outlined, the patient is:

- (1) Led to accept his personality assets and liabilities with greater equanimity and without loss of spontaneity and originality;

- (2) Unburdened of hampering sentiments and biased points of view;
- (3) Aided in attaining a better sense of values, as to time, spatial relations, dispensation of energy in terms of gain, and what constitutes success and failure;
- (4) Helped in the reformulation of his primary and/or secondary goals and the more healthy direction of his strivings;
- (5) Assisted in accepting his relative position in the group in terms of his dependency/independency tendencies;
- (6) Instructed as to what general pace in living and action he is most compatible with;
- (7) Influenced to develop and utilize more effectively his economizing functions of memory (repressions, et cetera) and emotional control;
- (8) Inspired to attain healthy and dependable habit patterns of implicit and overt activity in keeping with his *relative phase of life development* and the circumstances in which he must live.

In general, in my experience, it is not necessary except in a minority of instances, to work toward creating any special type of patient/physician relationship or "transference" situation in order to accomplish the goal of therapy. In my work the patient is encouraged to assume and at times he is actually charged with considerable responsibility for the alleviation of his disability and attainment of total unified adjustment and effective living.

To state that suggestive procedures and education in the broad sense are the tools by which we attain a therapeutic goal does not imply that the patient or at times even the therapist, in using them, must know *all* the whys and wherefores of all that takes place in treatment—any more than it is necessary for the patient and even the doctor to be aware of *all* that transpires when an antibiotic eradicates an infection and consequent pain and disability. The patient needs to know enough and to develop patterns of action and reaction sufficient to find a way of life with which he is more comfortable and in which he is more effective. The doctor, among other things, must at the same time be aware of what he himself does not know and understand, in order to keep constantly available to him opportunities for further attainment of fact, to encourage the development of his scientific curiosity, and to facilitate his synthesizing the various medical, surgical and psychiatric points of view in the interests of advancing medicine as a whole, for the specific purpose of promoting more effective living on the part of our people.

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PRACTICAL CONSIDERATIONS IN THE TREATMENT OF POLIOMYELITIS

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A discussion of poliomyelitis is particularly indicated at this time, since the incidence of the disease in the United States is the highest in history. The treatment and care of patients assumes added importance, due to our limited approach to certain other aspects of the disease. The details of the epidemiology and spread of poliomyelitis are not clearly delineated, although considerable information is available regarding many of the factors that are involved. There are no prophylactic measures of immunologic type against the disease in the human, nor are there specific chemotherapeutic or serological methods of stopping the disease in its early stage, so as to spare its destructive effect. Fortunately it appears that many people are not susceptible to the disease, at least in its full clinical form, and many who have the clinical disease have no paralysis, or so little paralysis that there are no residual effects.

We shall confine our remarks insofar as possible to practical considerations in the care of patients who have the disease, and this necessarily must be in abbreviated form. Other phases will be discussed only insofar as they are pertinent to the discussion of treatment.

CLINICAL MANIFESTATIONS AND THE PATHOLOGIC PROCESS

Chief clinical manifestations are those of flaccid paralysis, sensitivity of the muscles, and "muscle spasm." This makes for a particular deforming combination, in that, on the one hand, paralysis and weakness of the muscles prevent them from controlling the position of a part, and, on the other hand, other muscles are sensitive and tend to shorten, drawing the part into a deformed position. Furthermore, the sensitivity restricts the motion

with the result that the deformed attitude is retained continuously. It is characteristic of the neuromuscular system that positions long retained cause the shortened muscles to become permanently adapted to their new lengths, with the result that the deformity becomes fixed. This is true not only in poliomyelitis, but in other conditions as well. Ransom and Sams demonstrated this experimentally in 1928, and used the term "hypertonic contracture," rather than "muscle spasm," and further applied the term "myostatic contracture" to the fixed shortening which develops secondarily.

The flaccid paralysis, sensitivity and "spasm" are most variable in degree, distribution and duration. Both arise about the middle of the acute febrile illness.

Paralysis may or may not occur. It may affect a few muscles, it may affect practically all. It tends to be regional in its distribution, although a scattered involvement is common. Often one group of muscles about a joint are involved whereas the other groups in the area are intact. The individual muscles are affected in any degree from barely detectable weakness to complete paralysis. In duration, the paralysis may be transient or permanent. So-called spontaneous recovery of muscles may occur for a period of approximately 16 months, although most of the return occurs during the first year.

The prognosis for recovery of muscle power cannot be accurately estimated in the early stages of the disease, and this fact is an important consideration in therapy. One must treat the patient with the attitude that the musculature will recover, unless the elapse of time demonstrates that it will not. The greater the degree of paralysis at the start, the less likely is a muscle to recover, especially if the paralysis is equally extensive in other muscles of the region.

The sensitivity and spasm are of significance as deforming factors in the acute and early convalescent stages, and may, if their action has not been combatted during this time, contribute to residual disability. If contractures are allowed to develop, not only do they produce deformity, but they also inhibit the recovery and function of those muscles which are antagonistic to the deformed position. Furthermore, the sensitivity and spasm inhibit the action of muscles during this early period, and disorganization of reciprocal motion occurs.

The sensitivity and spasm are so constantly present that they represent one of the most valuable diagnostic features of the disease. Occasionally they are minimal and transient. Ordinarily they are present for a few weeks, although they may persist for a very much longer period. They represent contributory factors in the morbidity of the disease. The paralysis, its extent and permanence, is the significant thing. If paralysis does not exist, the sensitivity and spasm are of little consequence.

The pathologic process which produces this combination of symptoms is not understood in all details. The flaccid paralysis is due to the selective injury of the anterior horn cells, although effects of the virus upon the central nervous system are widespread, as revealed by histologic study. It should be emphasized that the action of the virus on the anterior horn cells supplying a particular muscle may vary in all degrees up to total destruction, and hence, from temporary neuronal injury with rapid recovery of function to irrevocable paralysis. It must likewise be considered that weakness of a muscle short of complete paralysis is due to the involvement of a particular portion of the anterior horn cells supplying that muscle. Furthermore, even in those muscles that appear to be completely paralyzed at the start, certain residual undestroyed motor units may remain. These are of importance in our consideration of therapy and may be designated as "guiding motor units."

The neurologic mechanism of the sensitivity and spasm is still in question. Many theories have been proposed, it has been suggested that it is due to lesion in the posterior ganglia; others have suggested that it is due to involvement of the internuncial neurons, whereas others have ascribed it to lesions higher in the nervous system, with particular reference to the reticular substance. Whatever the cause, clinically, the "spasm" resembles so-called reflex muscle spasm, the type which is seen in the muscles as associated with such conditions as painful joints or, in the instance of the muscles of the abdomen, in response to peritoneal irritation.

TREATMENT

The purpose of treatment, other than saving the patient's life, which is a factor in the bulbar type of the disease and the spinal respiratory type, is that of restoring the patient to as nearly normal musculo-skeletal function as possible.

In accomplishing this it is essential that attention be given to the musculo-skeletal system from the start of the disease. At our hospital, for example, the patient during the acute stage is a joint responsibility of the medical and orthopedic services. Although he is admitted to the medical service, during the period of quarantine, he is seen by the orthopedic surgeon at the start, who is responsible for the care of the musculo-skeletal system. At the end of two weeks the patient is transferred to the orthopedic service. The details of the arrangement are not important, but the need is for someone who understands the musculo-skeletal system to be concerned with the care from the beginning.

For practical purposes, treatment can best be discussed by classifying the disease into three stages, allowing that such a subdivision is artificial and one stage blends with the other.

1. *The Acute Stage*—is applied to the acute febrile illness and may be said to terminate 48 hours after the temperature has returned to normal, and after evidence of progressiveness of the process has ceased.

2. *The Convalescent Stage*—is described as a period during which muscles may recover their power and it may be said, arbitrarily, to end 16 months after the onset. This period may be subdivided into two phases: (1) the sensitive phase, and (2) the insensitive stage. The sensitive phase of the convalescent stage ends when the sensitivity and muscle spasm are no longer present.

3. *The Chronic Stage*—follows the convalescent stage, and although it might be described as the residual stage, it is a period when the functional capacities of the patient may be greatly improved, by factors other than the recovery of muscles.

ACUTE STAGE

In the acute stage, the treatment is mainly symptomatic. Bed rest is essential and the patient's activities should be minimal under these conditions. This can be emphasized by one particular consideration. It may be recalled that frequently the onset of poliomyelitis occurs in a diphasic or bacterian form, in which a nonspecific illness appears for a day or two, after which there is a period in which the child is apparently well, only to have a recrudescence of symptoms with signs referable to the central nervous system. If such a mild illness of nonspecific character, which could well be the first stage of the disease, occurs in the season of poliomyelitis, the child's activities should be curtailed for a sufficient period after the temperature is returned to normal to establish the fact that poliomyelitis is not present. There is evidence that fatigue and overactivity during this period increase the morbidity of the disease.

With the onset of paralysis other considerations arise. Careful attention should be given to the position of the affected parts, which should be supported gently and kept out of persistent harmful attitudes. A fixed position for any considerable

period should be avoided. The patient should be turned regularly. Particular areas of sensitivity and spasm may be relieved by using hot packs. In practice, the wool lay-on type of pack applied to particular areas, repeating the pack twice in a period of 30 minutes, makes a very desirable form in most instances. These may be used several times a day, if it is indicated. The patient should be made comfortable and sedatives should be employed as necessary unless the bulbar form of the disease exists.

During this stage of developing paralysis careful observation should be made for evidence of the bulbar form or of spinal respiratory involvement. It is in these types that death may occur.

Bulbar involvement is indicated by such signs as changes of voice, difficulty in swallowing, irregularity in respiration, and cyanosis. It may be associated with encephalitic symptoms. The spinal respiratory type in which the muscles of respiration are paralyzed is suggested by diminished respiratory excursion, asymmetry or other abnormal yet rhythmic motions of the chest, use of the accessory muscles for respiration, shortness of breath, and cyanosis.

The two types of involvement must be carefully differentiated since the method of treatment of one is entirely different from that of the other. In the bulbar type, the immediate indications are to keep the head dependent to allow for draining, suction of the pharynx, parenteral feeding, and manual aids to respiration if there are transient periods of difficulty. In the spinal respiratory type, on the other hand, the use of a respirator is indicated and may be lifesaving.

Occasionally, in the bulbar form, tracheotomy is desirable, if an airway cannot be adequately maintained. This is particularly true if the respiratory center becomes so affected as to lose its function, with the result that the patient must go in the respirator. It is likewise true if there is severe combined bulbar and spinal respiratory involvement which requires a respirator. Tracheotomy should be done only on specific indication. In the larger percentage of bulbar poliomyelitis, it is not necessary nor desirable. However, it should not be left as a last minute procedure, as anoxia of itself is destructive of the nervous system (and must be prevented).

Occasionally, in patients with a fixed elevated chest, repeated hot packs to the area may be helpful in reducing the spasm and in aiding respiration. Feeding by gavage is contra-indicated in the bulbar type of the disease. Prophylactic chemotherapy is desirable. Continuous nursing care is essential in this type. The importance of treatment in bulbar poliomyelitis is emphasized by the knowledge that although it is the type which causes most of the deaths from the disease, the majority of patients who survive it will recover completely, without residual abnormality.

THE CONVALESCENT STAGE: THE SENSITIVE PHASE

Return of the patient's temperature to normal marks no abrupt change in therapy, but treatment directed toward the neuromuscular abnormalities becomes more active. The patient is still sensitive. Handling of the parts must be gentle and motions of the involved areas should be assisted. Rest is still the most important feature of treatment. Hot packs may be continued as indicated to alleviate the sensitivity, and particularly before exercises.

Progressively, efforts are directed toward maintaining the desired anatomic positions, toward developing ranges of motion and toward stimulating the affected muscles to contract. Exercises are started as soon as the fever has ended. Gentle passive motions are performed several times daily, to carry the parts out of deformity and to increase their motion. Full arcs of motion of the joints in the affected areas should be developed as soon as this can be done comfortably. In timing, the exercises should follow the application of heat.

In maintaining the parts in as good position as it is possible, they are supported as necessary. Support to the feet, in particular, is needed, whether with a portable foot support or a board at the foot of the bed. The foot board with the mattress pulled away from the foot of the bed, after the manner used by Kenny, allows the foot to be maintained at a right angle when the patient is prone as well as in the supine position. The bed should be firm and straight. If, after the early portion of the sensitive phase, it is found that a part cannot be maintained in position by ordinary nursing care, bivalved plaster splints or other splints are used for support. Splints may be used a part of the day and at night, or at all times except during periods of exercise. Their use does not deviate from the principle that parts should not be left in one position for a long period. Other than affected feet and hands, most areas can be kept in good position with nursing care. Infants and very young children are more likely to need splints to keep their positions.

A fairly accurate estimate of the paralysis can be made 48 hours after the temperature is normal, or shortly thereafter. In addition to the clinical examination it is our practice at this time to have the physical therapist make a "muscle estimate," in which the individual muscles are graded and charted as to function. The examination is often performed in piecemeal fashion over several days. The patient should be disturbed as little as possible in performing this estimate and the usual positions for a muscle examination are not used. An official muscle examination is performed when sensitivity is reduced to a point where it can be done without disturbing the patient, usually two to four weeks after the onset. Such examinations are performed at regular intervals thereafter as they serve to record the progress of the patient and act as a

guide in therapy. During the first six months of the disease they are performed at monthly intervals; during the rest of the first year every two months; and thereafter less frequently.

Shortly after the passive exercises are instituted, gentle active exercises are added on a graduated scale. These are few in number in the beginning, and are increased gradually. At first they may entail only one or two contractions of the exercised muscle, in which the therapist assists the muscle by supporting and guiding the part through the motion. Even if the muscle cannot be felt to contract, the therapist slowly carries the part through the motion with the patient attempting to perform it. It is recalled that most muscles, even those badly affected, have a few residual "guiding motor units" remaining. The exercise will tend to keep the muscle in the pattern of motion.

The purpose of the active exercises at this time is to see that the muscle, which should perform an action, does it, even if it is ineffective. In performing the exercise, other muscles should not be permitted to substitute for the affected muscle.

The exercises are gradually increased in amount, at all times avoiding discomfort and fatigue. The number of exercises for each muscle is graded on the basis of its performance. If all the anterior horn cells for a particular muscle have been destroyed, active exercises for the muscle are of no avail, but during this early stage the degree of the injury cannot be determined.

As the patient becomes less sensitive, full ranges of motion are developed as they can be attained without hurting the patient. Those motions are emphasized which are opposite to the deforming tendency. In general, passive motions should be emphasized which are antagonistic to the muscles that have residual power and have a tendency to contracture. The physician must observe the patient carefully for deforming tendencies, and take appropriate measures against them. Early deformities of the spine, in particular, are likely to go undetected.

Underwater therapy is valuable in the sensitive stage as well as in the latter period of convalescence. The Hubbard Tub makes a convenient form for use, with the water at as high a temperature as can be tolerated comfortably by the patient. The heat decreases the spasm and sensitivity and allows the therapist to obtain greater ranges of motion, and assists in allowing the deformities to be corrected. In addition, the water acts as a buoyant medium to support the parts during the active exercises.

CONVALESCENT STAGE: THE INSENSITIVE PHASE

As the sensitivity and spasm regress the exercise regimen attains greater moment. Actual stretching of the contracted parts and of the areas that tend to contracture is often necessary. The back and the feet, in particular, require this.

The active exercises are increased. It is well to comment, however, that even at this stage the exercises are not of the character that the word "exercise" connotes to most of us. Usually they are limited to not over ten motions for the particular muscle at each period. The motive is still to make sure that the patient uses the muscle properly. As soon as the patient can perform the exercise properly against gravity, this position is used. During this period the weak muscles define the extent of the exercise in its particular area. Usually two periods of exercise a day are used at this time. Later exercises are added which are designed to develop synergistic motions and to produce hypertrophy. During this stage oftentimes support for parts which show deforming tendencies is still needed.

The patient is gotten up as soon as his condition permits. This, as well as all other phases of treatment, must be individualized, depending upon the amount of involvement. Even in the latter part of the sensitive phase the patient can, for short periods, be turned up into a sitting position of gradually increasing angle. When the patient is ready, sitting on the side of the bed is practiced with the position supervised. The feeling of normal position and balance is thus stimulated. If the paralysis is extensive, practice periods alone are held. Harm results from letting the patient sit for long periods in a bad position.

The transition into the standing attitude and into walking is supervised and gradual, depending upon the functional capacity of the patient. Deformed positions and bad attitudes are prevented. Only when the patient can carry out actions effectively and properly is he allowed to carry out these activities unsupervised. Otherwise, bad habits of use develop, and may be retained. Crutches may be desirable in early gait training if the arms have good musculature and the legs are weak.

Braces may be necessary for specific indications. They are not usually used, however, until the latter part of the convalescent stage. If the patient can walk satisfactorily with crutches without inducing deformity this is to be preferred, since this of itself is an excellent exercise. Braces, however, may be needed to prevent deformity, or indeed to allow walking at all. Support to the back and other areas may be indicated. After the convalescent phase braces should be used if they lead to a more effective gait, although it is often desirable even then to have periods of walking practice without them.

Treatment is as short or as long as necessary. Nothing is to be gained by forcing the patient along too rapidly in the convalescent phase, in which he is required to do things he can't perform effectively. One can move more slowly in the rehabilitation of a child than of an adult for socioeconomic reasons. Once, however, the potentialities of recovery are realized, or it becomes evident that

recovery in power will not occur, increasing activity is forced, using such artificial aids as are necessary.

Long hospitalization and protracted recumbency are necessary for only a small percentage of patients, occasionally for a year or longer. In 1947, for example, 4 percent of the patients admitted to our infantile paralysis wards were retained for a year or longer, 8 percent were in the hospital for 6 months, whereas 40 percent were discharged within three weeks. These figures will vary from year to year.

For most cases, the treatment during the insensitve phase of the convalescent stage or thereafter can be performed at home. Once the patient has been indoctrinated so that he does the exercises properly, the parent can be taught to perform them with the patient. The patient and parent are then seen at regular intervals to determine that the progress is satisfactory, and that the exercises by the parent are performed properly.

THE CHRONIC STAGE

In the chronic stage the problem is to make the patient as effective as he can be with what he has left. If there is imbalance of musculature in an area with deforming tendencies, regular stretching is indicated, which should be performed by the patient or the parent. Muscles of borderline strength should have exercises to produce hypertrophy.

Children who have paralysis need supervision at regular intervals during the period of growth since deformities may develop long after the initial disease. In the adult, once a static state is reached supervision is not so necessary.

Functional and gait training are important in this stage in those patients who have considerable residual paralysis. The patient is taught to perform his activities in the most effective and sightly way, allowing substitution of muscles as indicated. Even those patients very severely involved can, in most instances, be developed into individuals who are socially and economically independent if their

mental ability allows it. This may require protracted training. Patients with any considerable residual involvement should be given vocational guidance based upon a weighing of their aptitudes and their physical liabilities.

In many cases much can be done in the chronic stage toward rehabilitation by surgical measures. Tendon transplantation is useful in many instances in which a muscle may be transferred to carry out an action which is more important than its original one. Arthrodesis, or fusing of joints, is particularly valuable in the foot and spine. These and other procedures may allow an individual to discard braces; they may correct deformities, and result in great improvement in function.

It must be emphasized that if a patient has no deformities and is taught to use his musculature in the most effective way, essentially normal function in usual activities can be performed with a considerable muscle deficit.

SUMMARY

In summary, I would like to say that most patients with poliomyelitis become normal or nearly normal. If they have the nonparalytic form, treatment is of little consequence after the acute stage.

The bulbar or spinal respiratory forms demand particular attention in the acute stage since it is in these groups that death may occur. Proper constant care greatly reduces the mortality rate.

In the presence of paralysis, poliomyelitis is a very deforming disease. Much disability can be prevented by proper attention to the musculoskeletal system from the onset of the paralysis.

In the majority of patients, after the early period the treatment can be carried on at home, if it is properly supervised and the parents are carefully taught the regimen to follow.

Children with any degree of paralysis should be followed at regular intervals until growth is completed.

It is indeed the rare patient who cannot be made to walk, and to be socially and economically independent.



MEASLES ENCEPHALITIS

A report of twelve cases of Measles Encephalitis in Indiana in the first six months of 1948 with a brief review of the literature.

JOSEPH B. SEAGLE, M.D.*

ROCHESTER, MINNESOTA

THERE has been an increase in the number of cases of encephalitis as a sequela of measles in the last thirty years. This report is designed to summarize briefly some of the more important findings which have been reported in this complication of measles and to add twelve cases which were admitted to the James Whitcomb Riley Hospital for Children during the six-month period between January 1, 1948, and July 1, 1948.

From January 1 through July 1, 1948, there were 16,981 cases of measles reported to the Indiana State Board of Health, this number being over 5,000 greater than any reported figure for the corresponding periods during the past five years. The number of children diagnosed as having measles encephalitis at the James Whitcomb Riley Hospital in the first six months of the years 1943 through 1947 varied from none to eight, with an average of 3.2 cases per year. Table I illustrates a rough correlation between the number of reported cases of measles in Indiana and the cases of measles encephalitis admitted to Riley Hospital during this period. It may be noted with interest that there have been no cases of measles encephalitis admitted to Riley Hospital between July and January of this five-year period. It has been pointed out previously that the first seven months of the year account for the majority of the cases of measles in most epidemics, and, in consequence of this, the majority of the measles sequelae.¹

The twelve children in this series were admitted to the hospital from eight hours to sixteen days after the first signs of encephalitis appeared, with symptoms being noted for an average of 3.5 days before admission. The youngest patient in the series was thirteen months old, while the oldest was nine years of age. There were eight girls and four boys in the group. The twelve children represented admissions from eight different counties in central and north central Indiana. Although it is difficult to determine the correct incidence of measles throughout the state due to unreported and unrecognized cases, the eight counties involved reported 28.6 percent of the cases of measles reported to the Indiana State Board of Health during this period. The same counties represented 21.0 percent of the total population of the state.

* From the Pediatric Department, Indiana University School of Medicine and the James Whitcomb Riley Hospital, Indianapolis.

TABLE I
Incidence of measles reported to the Indiana State Board of Health and measles encephalitis at Riley Hospital

Year	Reported cases of measles between January 1 and July 1	Riley Hospital measles encephalitis
1943 -----	8,709	5
1944 -----	5,250	2
1945 -----	626	0
1946 -----	11,650	8
1947 -----	1,699	0
1948 -----	16,981	12

Hoyne and Slotkowski² in 1947 reviewed the work of seven different authors who had cited the incidence of postmeasles encephalitis in various measles epidemics as varying from 1:15,000 to 1:642. It is believed by some clinicians^{2, 3, 4} that there has been an actual increase in the incidence of this sequela of measles in recent years.

The onset of encephalitic symptoms is generally accepted to be from two to six days after the measles rash first appears. However, it should be borne in mind that encephalitis may precede the rash or occur up to twenty days after the appearance of the rash.

SYMPTOMATOLOGY

The symptomatology of encephalitis complicating measles varies considerably, depending upon the part of the central nervous system involved. Neurological signs are frequently bizarre and may be inconsistent from day to day.^{3, 5, 6} The onset may be abrupt, with convulsions or extreme irritability, restlessness, and delirium; or it may be gradual, with lethargy slowly deepening into coma. Irritability, listlessness, delirium, aphasia, plus various personality and psychic changes may occur, any or several of which may regress rapidly or linger for months or years. Hamilton and Hanna reviewed 241 cases of measles encephalitis in 1941 and stated that the cranial nerves are more commonly affected than the peripheral nerves. The effects of involvement of the cranial nerves include speech defects, ocular defects, such as inequality of the pupils, deafness, and facial or pharyngeal paralysis. Convulsive seizures, either local or generalized, are not infrequently observed. The deep reflexes may be found to be hyperactive, hyporeactive, or normal. The superficial reflexes frequently are absent. Stiffness of the neck and a positive Kernig's sign are other common findings. Urinary retention is occasionally noted.

The spinal fluid findings in measles encephalitis are also variable and inconsistent. Litvak³ states that some cases show no deviation from the normal spinal fluid. The opening spinal fluid pressure is usually elevated, but may be normal.⁷ In Hamilton's series of cases the spinal fluid white cell count varied from 0 to 700 cells per cubic millimeter, with an average of 131, 81 percent of which were lymphocytes. Cell counts of 1,000 or above are rare, but have been reported. The spinal fluid total protein is usually elevated, and the spinal fluid sugar may be normal, elevated, or subnormal.

RILEY SERIES

In our cases encephalitic symptoms first appeared from three to five days after the rash, the average time lapse being 3.6 days. The first symptom of cerebral involvement in three of our patients was a generalized convulsion. Unconsciousness or extreme lethargy, disorientation, headache, or irritability were the first indications of this complication in the others. Three of the children were unconscious at the time of hospital admission, while six responded to painful stimuli only. In seven of the twelve children a history of generalized convulsions was obtained as a part of the present illness. Four of the remaining patients had involuntary contractions of localized groups of muscles.

PHYSICAL EXAMINATION

Physical findings at the time of admission and during the hospital course varied, as did the early symptoms. As noted above, nine of the twelve children were unconscious or disoriented when first seen. All appeared acutely ill and were unable to take sufficient solid or liquid feedings by mouth to maintain adequate body metabolism. Dehydration was present either in a moderate or severe degree in most cases, and a fading measles rash was observed in every case by the admitting physician. Nuchal rigidity was present in three of the children. The tendon reflexes were considered hypoaactive in five patients, hyperactive in four, and normal in three. Various tendon reflexes were absent in several of the children. The Babinski sign was absent in all cases, and the Kernig sign was present in only one. Urinary retention was noted in two of the children, presenting a major problem in one patient who required catheterization for twenty-nine days after hospital admission.

COMPLICATIONS

Six of the children had more than one complication during the course of their illness. Four had a patchy pneumonitis at the time of admission, and one had a bilateral otitis media when first seen two days following the first symptoms or signs of encephalitis. Another patient developed a thrombophlebitis in both legs during his eight months of hospitalization. Excluding these six cases, it was found that the highest rectal temperatures in the remaining six children were between 101 degrees F. and 105 degrees, these being recorded on an average

of 2.7 days after the onset of encephalitis. A rather marked fall in temperature was found within the first forty-eight hours of hospitalization in several patients. This was attributed chiefly to correction of dehydration by parenteral fluid therapy. Despite the above mentioned early fall in temperatures, it was an average of 9.3 days before the six uncomplicated cases had stable rectal temperatures at or below 100 degrees.

LABORATORY DATA

The spinal fluid findings of the Riley Hospital patients are tabulated in Table II, with the number of days after the onset of encephalitis indicating when the lumbar puncture was done. Spinal fluid white cell counts ranged from 0 to 1,050, six of the twelve being ten or below. The count reported as 1,050 was questioned by attending physicians, since the fluid was grossly clear, no differential was done, and the spinal fluid examination when repeated four days later revealed a higher total protein and only 5 white cells. Spinal fluid total proteins in the initial lumbar puncture were between 37 mg. percent and 360 mg. percent. Two were in excess of 100 mg. percent; both of these patients were severely ill and had protracted periods of hospitalization. Spinal fluid sugars on the initial examination were between 42 mg. percent and 108 mg. percent.

TABLE II

Summary of data on spinal fluid of patients with measles encephalitis

Case	Days after onset of encephalitis	Cell Count	Total protein Mg./100 cc.	Sugar Mg./100 cc.	Gold curve	Severity of encephalitis
1	6	0	59	51	0000000000	Severe
2	1	1	61	100	1112211000	Mild
3	4	12	41	43	1112222100	Mild
4	0	860	360	94	0000011100	Very severe
5	0	10	45	108	0000000000	Mild
6	2	30	64	44	0001210000	Severe
7	5	1,050 (?)	150	42	0255555510	Very severe
8	4	10	41	63	1112221000	Very severe
9	0	13	63	74	0001110000	Mild
10	16	4	37	53	0001110000	Severe
11	3	7	48	76	Not done	Very severe
12	0	657	75	77	Not done	Fatal

Complete blood counts revealed a moderate leukocytosis with a predominance of polymorphonuclear leukocytes. Two children had white cell counts of 20,000 cells per cubic millimeter. The average of the twelve cases was 13,602 cells per cubic millimeter at the time of admission.

A detailed study of the siblings of our patients was conducted in an attempt to learn whether any other children in the respective families had suf-

ferred a complication of measles. A total of twenty-four siblings was investigated. Twelve of these had measles within a three-week period prior to or following the onset of their siblings' illnesses, five had measles in previous years, and five had never had measles. Only one of the nineteen siblings who have had measles had a recognized complication, otitis media, although two siblings who contracted measles in the same epidemic as the Riley Hospital patient were said by the parents to have had a "severe form of measles." In most cases an effort was made to ascertain the severity of the sibling's measles as compared with that of the patient. We found no evidence that the symptoms of our patients were more severe prior to their encephalitis than were those of their respective siblings. Stimson,⁸ McKahann⁹ and others state that there is no apparent relationship between the severity of measles and the occurrence of encephalitis.

MANAGEMENT

The medical management of these patients, while not specific, is extremely important. Since the course of measles encephalitis is not altered consistently by any specific therapy, every available means must be used to maintain adequate nutrition and hydration, to combat secondary infection, and to maintain the patient's general health. All of our patients were given parenteral feedings at the time of admission. The majority received intravenous infusions, some being supplemented by hypodermoclysis. Sterile saline and glucose solutions were used in these cases, dosage being based upon the age, size, and state of hydration of the patient. Only isotonic saline was administered subcutaneously. Precautions must be taken, of course, against overloading the circulatory system. When necessary after the temperature returned to normal levels, gavage feedings were employed to maintain hydration and nutrition. High caloric, high vitamin feedings were continued until the patient was able to tolerate fluids by mouth. Gavage feeding was continued in one patient for twenty-eight days. The tains one calorie per cubic centimeter. One hundred cc. of gavage mixture contains approximately 11.5 grams carbohydrate, 5.2 grams of protein, and 3.3 grams of fat. Vitamin B and C concentrates were added to the feeding.

Good nursing care was considered of utmost importance, especially in children who were unconscious or disoriented. Frequent turning and moving of the patient, proper care of the skin, and support of flaccid extremities were all stressed. Daily physical therapy was a routine procedure in all children with a prolonged illness. Ten of the twelve patients were given penicillin, either to combat active infectious processes, or as a prophylactic measure in unconscious or semiconscious patients. Crystalline penicillin, 30,000 units every three hours intramuscularly, was used.

Convulsions and other evidences of excessive cere-

bral agitation were controlled in our patients with either paraldehyde or phenobarbital. Phenobarbital was usually administered in doses of 1½ or 3 grains, by rectum or subcutaneously. Paraldehyde was employed in doses of 4 to 6 cc. by rectum, being repeated in six hours when necessary.

Magnesium sulfate, either by mouth or intramuscularly, has been recommended by some authors.⁷ Lumbar puncture for the release of spinal fluid under increased pressure is not employed at Riley Hospital, although it has been discussed by several authors^{3, 4, 7} in the management of measles encephalitis. Other therapeutic measures, which we have not used but which have been tried by some physicians, are convalescent measles serum administered intrathecally, intravenously, or intramuscularly, inoculation with encephalitis vaccine, and foreign protein therapy, i.e., mixed typhoid vaccine.

COMMENT

It has been stated that approximately 40 percent of patients with measles encephalitis will recover completely, 40 percent will be left with major or minor residual symptoms, and 20 percent will succumb to the disease.⁶ The prognosis must be guarded early in the course of the illness since there is no definite correlation between the early symptoms and condition of the patient and the ultimate outcome. Weakness of various muscle groups is the most common physical residual, while choreiform or athetoid movements, ataxia, and epilepsy are not uncommon. Ford has stated that mental changes, such as impairment of intelligence, irritability, instability of mood and sleep disturbances, are the most common of all residuals and are found in nearly one-third of the cases.

Table III illustrates the urgent need for the prompt institution of supplemental feedings, physical therapy, and measures to prevent secondary infection. Patients with measles encephalitis may recover with physical residuals absent or present only in a minor form, even after days or weeks in a semiconscious state.

Although the follow-up period of our patients is necessarily short at this time, seven of the twelve children when last seen in the Out-Patient Clinic were considered physically normal. One nine-year-old girl presents a flaccid paralysis of muscles of the left hand and arm, as well as hypertonicity of the right leg. A nine-year-old boy who developed thrombophlebitis is still in the hospital eight months after the onset of encephalitis, with weakness of all extremities and limited motion of the legs. A third child, fifteen months of age, does not yet hold his head up or sit, and may have visual and auditory impairment. A fourth child, four and one-half years old, is being treated as an out-patient for spasticity of the right leg.

Three children are considered normal emotionally and mentally by their parents at this time. In

TABLE III
Physical and emotional conditions of measles encephalitis patients when last seen, with total days of hospitalization.

Case	Physical condition	Emotional or psychological disturbances	Days of hospitalization
1	Normal	Slight	42
2	Normal	Normal	9
3	Weakness of hand and arm. Hypertonic lower extremity	Severe	26
4	Normal	Moderate	56
5	Normal	Slight	9
6	Normal	Moderate	47
7	Spastic lower extremity	Slight	69
8	All extremities weak. Spastic lower extremity	Severe	245 (not discharged)
9	Normal	Normal	7
10	Normal	Normal	12
11	Does not hold head up. Possible visual or auditory damage	Unknown	36
12	Fatal	-----	4

seven cases the parents have noticed emotional instability, changes in mood, or excessive irritability since discharge from the hospital. Psychological examinations have been done on some patients, but the results of these examinations are not considered significant at the present time without further appraisals at intervals in the future.

One patient, a five-year-old girl, died four days after generalized convulsions indicated the onset of the encephalitic process. At postmortem examination the typical microscopic findings of diffuse myeloencephalitis were observed in the brain, along with early bronchopneumonia and patchy atelectasis of the lungs.

SUMMARY

Twelve cases of measles encephalitis admitted to the James Whitcomb Riley Hospital for Children

between January 1 and July 1, 1948, are presented, with a brief review of the important clinical findings of this disease.

Of the twelve children, one died, four were left with some physical disability, and seven were physically normal when discharged or last seen.

The medical management of this sequela of measles has been stressed with emphasis on the maintenance of body nutrition and fluid balance, good nursing care, and prophylaxis against secondary infection. Emphasis should also be placed on the necessity of a guarded prognosis at the onset of measles encephalitis, as well as on the frequent recovery with minimal physical residuals despite a severe, prolonged illness.

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EPIDERMAL AND DERMAL SENSITIZATION FROM MERCURY: ITS EFFECT ON VISION AND NAIL GROWTH

L. EDWARD GAUL, M.D.

G. B. UNDERWOOD, M.D.

EVANSVILLE

INORGANIC and organic mercurials have wide therapeutic and cosmetic application on the human skin. The development of sensitization dermatitis from mercurials is due in a large measure to their application to injured skin, whether from mechanical, physical, chemical or infectious causes. A patch test survey of the organo-mercurials disclosed an incidence of 46 percent reactions to ammoniated mercury, 13 percent to merthiolate, 28 percent to metaphen, 24 percent to mercurochrome, and 20 percent to mercresin.¹ Therefore epidermal sensitization from the organo-mercurials is relatively common. When the epidermis is sensitized to a mercurial, if a mercurial reaches the dermis either by ingestion or by parenteral use, violent eruptive manifestations can occur on the skin. Sudden deaths from the mercurial diuretics have occurred. The following report of a case illustrates the dermal and epidermal response from ingesting calomel in a patient whose epidermis was sensitive to ammoniated mercury.

CASE REPORT

Case L. R., a white male aged 10, was observed for a generalized dermatitis. An eczematous and urticarial response was present. On the left distal forearm, the eczematous reaction displayed a triple zoning (Figure 1), a frequent sign of overtreatment. The central zone showed an intense inflammation, with weeping, crusting, pustulation and hemorrhage; demarcated by a raised border of closely packed vesicles. The skin in the intermediate zone appeared normal except for loss of pigment and apparent dehydration. The peripheral zone consisted of a serpiginous band made up of vesicles and urticarial lesions. The right forehead, cheek, chin, distal forearm, and shins showed discrete patches of eczematization. The urticarial reaction was pebbly, without erythema. The color of the skin was light olive. Symptoms were absent. The mucous membranes were not involved. A physical examination was not unusual. Laboratory examinations were normal except for a one plus sugar and albumin in the urine. An ophthalmological examination disclosed vision of 20/30, and a haziness of both corneas. A week later, the vision was 20/20, and haziness had cleared.

The mother revealed that two weeks before she had applied ammoniated mercury, 5 percent, to an abrasion on the left forearm to prevent infection. This did not heal so the mercury was continued. At the end of a week it seemed that infection had

set in. The dermatosis was self-diagnosed impetigo instead of a primary overtreatment reaction.² Ammoniated mercury, 10 percent, was now used locally; and to help things along, it was decided to worm the children. A proprietary containing santonin and calomel, each grains $\frac{1}{4}$ (0.03 gm.), was administered, three tablets in

Figure 1



Case L.R., Epidermal and Dermal Sensitization from Mercury.

twelve hours. The three younger brothers received the same dose. Twenty-four hours after the last tablet, the children were given a laxative dose of milk of magnesia. Thirty-six hours after the first calomel tablet, the dermatitis on the left forearm showed eruptive signs. The eczematous patches became manifest, followed by the urticarial reaction. His brothers were not affected. The dermatitis improved under care and management. The urine was normal in four days. Two weeks later he returned to school, and within three weeks the skin was almost clear. At this time it was noted that the finger and toenails showed a deep lateral ridging. The nails became normal within three months. A patch test with ammoniated mercury, 1 percent, was four plus in twelve hours. It was considered unwise to risk a dose of calomel by mouth.

COMMENTS

Case L. R. is unusual because of the eye involvement and the effect of the eczematous and urti-

carial reaction on the growth of the nails. An exposure history was adequate. The eczematized areas had had a previous exposure to mercury; in fact, this was the family antiseptic. Cook³ cited two cases of epidermal and dermal sensitization to mercury. Templeton⁴ reviewed the literature and reported cases illustrating epidermal and dermal sensitization to chloral hydrate, sulfathiazole, arsphenamine, camomile, various foods, and poison oak extract. Rhus extracts also are common offenders.

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LETTER TO THE EDITOR

To the Editor:

There have been many inquiries recently regarding the arrangements for covering the cost of care for poliomyelitis patients. There are a number of factors which will be of interest to your readers.

During 1949 a poliomyelitis incidence of unprecedented size (more than 37,000 stricken since January 1) has put serious financial strain upon the National Foundation for Infantile Paralysis. For the first time in its eleven year history it was necessary to conduct a Polio Epidemic Emergency Drive which although very helpful did not entirely meet current needs.

In its avowed purpose to lead, direct and unify the national fight against infantile paralysis the National Foundation undertook support of research and education, for in these areas lie the ultimate hope for eradication of poliomyelitis. These programs are not to be compromised in any way.

The greatest cost to the National Foundation, however, is payment for medical care to patients. It is urgent for all physicians to assist in the institution of measures which will reduce costs without prejudice to patients. The chief costs are for hospitalization. Many poliomyelitis patients are hospitalized when they can be cared for at home at a reduced cost.

Our experience in this year's epidemic which has spared virtually no part of the country suggests the following:

1. Abortive, nonparalytic and mildly paralytic

poliomyelitis patients are being hospitalized in the mistaken idea that the stated period of isolation must be spent in the hospital.

2. Overly prolonged hospitalization is frequent. This is particularly true of the paralytic patient who has achieved maximum improvement from daily physical therapy. Home care with periodic office or clinic visits is then in order.

3. There still exists in some places a general attitude that poliomyelitis is a bizarre disease which only a few physicians can manage. This is not so. It is disturbing, for example, to find physicians leaning so heavily upon the guidance of physical therapists and nurses. The physician's assessment of the total patient is the best index in determining when a patient shall leave hospital to receive home, office or clinic care.

4. Patients hospitalized on general ward services are not charged medical fees ordinarily. When patients are hospitalized on isolation wards for poliomyelitis, however, bills for medical fees are at times submitted. Payment is frequently made by the local chapters of the National Foundation whose treasuries are now generally depleted.

It is hoped that your readers will understand clearly how urgent is our need for cooperation from all practicing physicians in the matters mentioned above.

Sincerely yours,

National Foundation for Infantile Paralysis, Inc.
Hart E. Van Riper, M.D.,
Medical Director.

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POLICE STATE METHODS

EARLY in October an A.M.A. news release revealed that FBI men were examining the records of the association, and that similar proceedings were scheduled for some of the component state and county medical societies. The investigation was found to have originated in the Anti-Trust Division of the U. S. Department of Justice.

The announcement created a strong response from newspaper editors in all parts of the United States. Few missed the fact that the investigation occurred at a time when the medical profession is campaigning against compulsory government insurance. None thought that this was a coincidence.

Editorial comments have been blistering and scathing. They were surprisingly in agreement in labeling the attack as an attempt to intimidate the profession, and to force the adoption of socialized medicine. *The Seattle Post-Intelligencer* summed up the conclusions of many writers by saying "The socialist minded Truman administration, impatient of delay in setting up the police state it advocates, thus adopts the methods of the police state in advance."

Subsequent to the A.M.A. announcement, Attorney General J. Howard McGrath admitted that the Department of Justice was in the process of investigating the A.M.A. He also said that the investigation was initiated by complaints of an alleged effort to "monopolize" prepaid medical care.

When Mr. McGrath was a member of the U. S. Senate he was one of the government's outstanding advocates of compulsory health insurance. As we understand the plans for compulsory health insurance, it is the intention of those who favor it to create a monopoly in medical care. It is difficult to understand how the socializers could go all out for such a super-monopoly, and then stoop to criticize the medical profession for promoting a voluntary system of plans which are extremely numerous, completely independent, and which are as far from a monopoly as would be possible.

While the growth of physician-sponsored health plans has been tremendous, it is a well-known fact that all types of health insurance contracts have enjoyed a similar mushroom growth. Commercial insurance carriers have been quick to point out that the public interest in, and the demand for medical insurance has been greatly enhanced by the organization and promotion of insurance plans by the medical profession.

Soon after the A.M.A. release, the Insurance Economics Society issued a statement to denounce what it called "police state methods." E. H. O'Connor, executive director of the society, stated that the A.M.A. had never made any attempt to monopolize prepaid medical care. "Actually the medical profession is doing exactly the opposite," he asserted. "The American Medical Association is mak-

ing a nation-wide survey to promote all types of voluntary health insurance."

These are strong and honest words. Since they are uttered by a representative of the insurance companies which are presumably the "victims" of the alleged efforts at monopoly, they should go a long way toward disclosing the real mission of the FBI investigation.

The Board of Trustees of the A.M.A. has stated that they consider the investigation as a campaign to discredit American Medicine and terrorize physicians into abandoning their opposition to compulsory health insurance.

Dr. Ernest E. Irons, president of the A.M.A., emphasized at the time of the news release that physicians would continue to oppose compulsory health insurance despite all government efforts to "terrorize them."

THE CHALLENGE

THE medical profession has fallen upon evil days: the science is lauded to the skies, but the doctor himself is being pictured as grasping and self-seeking. It is as though a concerted effort were being made to divide him body from soul. However, several factors make for the ultimate salvation of the medical profession. First—more will always be demanded of us than we will ever be able to accomplish. Secondly—the practitioner and the art of practice will never be completely understood nor appreciated by the public, no matter how much we may try to take our patients into our confidence. The realization of these truths will tend to keep us humble, and humble men are always good candidates for salvation.

The urgent problems now confronting medical men and demanding solution are of a social, political, and economic nature. Medical training alone cannot provide us with the background to meet these problems. The quality of statesmanship which the gravity of the situation demands has been nurtured in times gone by through study of the humanities and the arts, but these disciplines have well-nigh vanished from the contemporary medical scene.

The recent graduates in medicine have had to confine their thinking almost entirely to the sciences throughout their premedical, medical, and postgraduate training. This narrowing of experience is even more marked in the fields of pure science which are the handmaidens of medicine.

The result is that we have a group of the best trained physicians the world has ever seen, but a group which is none the less profoundly ignorant outside its chosen field.

An educated man, according to Plato, is one who is able and willing to see things as they are. The ability to do this is almost impossible to acquire without a knowledge of recorded history along with an understanding of philosophy, art, and literature. It is not that doctors cannot think well, we have proved to the world that we can, but we need to think with minds experienced in the broad course of social striving and rooted in our cultural origins.

Health is important but it is not the end of all of man's endeavor. Good health merely adds to man's capacity to make greater contributions in the realms of religion, art, music, ethics, philosophy, poetry, and science. "No activity of man is significant finally except as it is expressed in these realms." (Lewis Mumford.)

Unless we be content to be relegated to the role of medical technicians, we must meet this challenge. We must remember that Shakespeare and Montaigne are not yet proscribed reading even for medical students. We must let the Muses dance before the altar of science, remembering that even in medicine there is that being which Ortega y Gasset calls "an educated ignoramus."

*George A. Collett, M.D.
Elko, Nevada.*

HE WHO RUNS—

DOCTORS are a long-suffering, plodding and rather shy breed. They are glad, for the most part, to do their work as well as may be, and then move on to the next problem, with no least thought of taking a bow for their work.

Indeed, compliments on a doctor's work are bound to be scarce in the nature of things. Many will praise the architect for his beautifully designed house or his imposing post office, but who will say, "Doctor, that was a masterly bit of bone-setting"—or, "What a breath-taking thoracoplasty!"

Here, the G. P. has the advantage over the specialist because he does more things that people can understand. Specialists are either highly technical in their ways, or else work entirely "inside." In the latter instance only one person, the patient, can tell that he feels better, and in the case of the most most beautiful perineorrhaphy in the world, only one lay observer may legally appreciate it.

So it goes, and the doctors are not one whit disgruntled. If one has perchance read this, he will now say, "Ho, hum!" and open the door to his next patient.

WARNING!

Dr. H. Boyd Stewart, president of the American Society of Anesthesiologists, in a recent issue of the *News Letter* of that society, discusses a situation which should have the sober attention of all physicians, regardless of their type of practice. If the charges are based on fact, they are a good example of what has been said many times; the thoughtless and indiscreet actions of a very small percentage of the profession can cause a worsening of public relations for the entire group.

Dr. Stewart's discussion is reproduced below:

"From many sources over the United States, I am hearing increasingly numerous reports that surgeons and anesthesiologists are being cited in contempt by the public in their relations with patients who are insured under Blue Cross and Blue Shield Plans. The universal charge against the physician is that he is guilty of exploitation of his patient by accepting a fee from a prepayment plan and then charging the patient a private fee as large as he was accustomed to levy before the patient had insurance. More than half the Blue Shield Plans in operation are on an indemnity basis, permitting the physician to charge the patient a fee over and above the amount allowed by the plan. The patient who knows what legitimate and customary fees should be is becoming highly incensed at this exploitation and is asking the question, 'Who is the one insured and protected under these voluntary plans, the patient or the physician?'"

"I think every physician, who may be tempted and yield to such practice, should constantly keep before him a few salient facts. Most of these voluntary plans have been sponsored by and are being operated under the supervision of the medical profession. The over-all success of the plans depends almost entirely upon the integrity and cooperation of the profession. They were instituted in the beginning to do a job, in applying the insurance principle of spreading the cost of medical care over a large group. At the present they are our biggest weapon against federal attempts at compulsory health plans. The public by and large has been well pleased with the coverage they have received.

"It behooves the individual physician, who participates in and who is reimbursed by these plans, to use discretion and observe honesty lest he inadvertently contribute to a justifiable wave of resentment. As anesthesiologists, we must not allow ourselves to become a part of such practice and above all we must assume our responsibilities for the success of medicine's effort in behalf of the patient and against federalization of the practice of medicine."

INDIANA ROOF HAS LOST ARTICLES

A collection of articles lost at the recent Centennial banquet, on September 29, at the Indiana Roof are being held by the management. Owners may procure them by contacting Miss Alice McMahon, the manager, and making proper identification.

Editorial Notes

GENERAL PRACTITIONER OF THE YEAR

Dr. Charles C. Crampton of Delphi was selected by the House of Delegates during the Centennial Session as the General Practitioner of the Year. In this capacity he will be the Hoosier nominee for similar national honor to be bestowed during the Clinical Session of the A.M.A. this month, in Washington, D.C.

The general practitioners of Indiana, and indeed all physicians, may be proud to be represented in the public eye by a doctor like Doctor Crampton. At the age of 77, he is still active and vigorous, and carries on his practice as he has for 56 years. Besides his medical work he has found time to devote to many civic interests. During World War I he served with the Army overseas, although at that time he was approaching the age of 50.

At the Annual Dinner of the Association he was presented with an oil painting by V. J. Cariani, one of the renowned members of the Brown County colony of landscape artists.

The medical profession of Indiana is honored by such a representative, and wishes him many more years of happy and successful practice.

READ THIS

"Being a federal employee, I am not at present eligible to belong to a state or county medical society and consequently am not a member of the American Medical Association. Also being on a federal salary I am scarcely able at this time to contribute the entire \$25 toward defeat of the vicious so-called health bill sponsored by Oscar Ewing and others. I am, however, enclosing a check for \$10, which I hope will help a little in defeating this proposed legislation. I know at first hand what federal medicine does to a doctor, and I know what it does to patients."

The above-quoted cogent letter was written by a physician in the Indian Service and was published in *The Journal of the Oklahoma State Medical Association* for November, 1949. Just above this letter appears the following editorial:

"As we go to press we hasten to let our members know that The Oklahoma State Medical Association is among the 20 odd state and county medical societies coming under the scrutiny of the Department of Justice through an investigation now being conducted by the F.B.I.

"This is something every member of the Association should have in mind as he goes about his daily duties. The December Journal will carry more complete editorial information.

"In the meantime all members should seriously consider the significance of this investigation."

We would infer from the juxtaposition of these two pieces in their journal that our brothers in Oklahoma have no lack of courage and human understanding.

RETAIL DRUGGISTS TELL EWING

The National Association of Retail Druggists adopted a resolution objecting to compulsory health insurance at their annual convention in New York City in September. The resolution was passed by the delegates after Oscar Ewing had delivered a speech favoring compulsory insurance. Mr. Ewing is quoted as stating, "In all this I do not see how the retail druggist can fail to profit enormously."

Robert L. Lund, president of the St. Louis College of Pharmacy, hailed the resolution as the rejection of "an appeal to the pocketbook rather than to principle."

"It's reassuring to all of us who are concerned for free American institutions to know that the druggists of this country believe that the question of the people's health should be decided on principle and on the basis of achievements of our existing medical system, recognized to be the finest in the world," Lund continued. "The druggists of America have shown clearly that, so far as they are concerned, this question is not to be answered by any appeal to the short-term, selfish, commercial interest, but by reference to the true principles and values involved—the welfare and the freedom of all Americans."

The American Legion and the Legion Auxiliary, at their national conventions in Philadelphia, recently reaffirmed the stand taken annually since 1945 by adopting a strong resolution against Compulsory Health Insurance.

The Legion, with a national membership of 3,500,000, and the Legion Auxiliary, composed of more than 1,000,000 women, passed the following resolution:

WHEREAS, the American Legion has always had as one of its objectives to foster and perpetuate a 100% Americanism and to safeguard our liberties and freedoms as opposed to any form of compulsion and regimentation, and

WHEREAS, there is now before the Congress of the United States the question of Compulsory Health Insurance which in itself is a threat to our freedom, now

Therefore be it resolved by the American Legion in National Convention assembled August 29-September 1, 1949, in Philadelphia, Pennsylvania, that this organization go on record as opposing any form of Compulsory Health Insurance.

A recent review of the British National Health Service, conducted by *The Practitioner*, and summarized in *The British Medical Journal*, consists entirely of anonymous articles. The latter journal comments editorially that "Men working in a 'service' hesitate to put their names to anything in the nature of a criticism of it. . . . It is a sad and sorry comment on Medicine today to admit that only under the cloak of anonymity is it possible to speak the mind with complete freedom on what the same editorial describes as 'one of the greatest ventures in the history of medicine.'"

"A MORAL ISSUE"

UNDER the above title appears an editorial in the September, 1949 *Connecticut State Medical Journal* which we believe merits quotation almost in full. Note the cogent statement: "The worth of a doctor is not in man-hours."

"The distinguished writer Cecil Palmer tells us elsewhere in this issue that it is on moral grounds primarily that we must fight to preserve private practice in medicine. He also says that the situation in Great Britain is such that it appears that a recovery of the previous position of medicine is not possible. This has been affirmed recently by the Conservative Party in a booklet stating in clear language what it would do and undo if it could. Among things the party claims it cannot do is to drop the National Health Service, food rationing, and price controls. However, democracy is not dead in Great Britain nor will it die, as long as its citizens are not afraid to say what they think. We will not forget that in these dark times this nation is proving itself a great people, true to a tradition whose roots have been deepened by centuries of conquest for the rights of the individual. Our own freedom was largely shaped by men who were once British subjects and as such inherited the same birthright.

"The medical profession in our country as an influential and indispensable social group must face the reality of their present position. They have other social responsibilities than those of the sick room. Today calls for a continuing emphasis of the recognized inherent values and ideals of American medicine. This should be done in medical schools, medical societies, and other professional groups to the end that the public will realize what these things mean to their own welfare and protection. The worth of a doctor is not in man-hours.

* * * * *

"In what was meant as derogation the profession has been said to be made up of incurable individualists. Let us accept the appellation and prove that we are also incurable Americans. The issue before us is indeed a moral one and no one has stated it more clearly than Archibald MacLeish in a recent issue of the *Atlantic Monthly*: 'Stated in terms of structure, the real alternatives are, at the one pole, a cellular, authoritarian society in which individual human beings may live their lives through the life of society as a whole, and at the other, a world of individual men, whose relation to each other, in the freedom of their individuality, will create a society in which each can live as himself.'"

A preliminary report released by the Public Health Service on the air-pollution study at Donora, Pennsylvania, indicates that scientific proof has been obtained to show that contamination of air in industrial areas can cause serious acute disabling diseases. In addition to twenty deaths, about 43 percent of the population of the area were ill during the five-day smog in October, 1948. The Division of Industrial Hygiene is continuing the study in this area. By invitation it is extending its research to other industrial areas, and hopes to determine the etiology and prevention of diseases which are caused by air contaminants.



President's Page



Greetings

AT THIS yuletide season I wish to extend greetings and good wishes to all of you.

As we approach another anniversary of the birth of Christ, let us pause to consider Him who also healed the sick. No other life in history has ever been lived which served mankind with the same selfless devotion, the generous heart, the faith in others that characterizes the life of the Son of God. It is His life which we hold as the pattern for our own. As doctors, we too are dedicated to live for others. Our profession is, in fact, a divine trust, and its purpose is to serve all people alike, giving each our best in effort and ability. Because of this we must guard our profession so that its standards will not be lowered either through inferior service by ourselves or through political management by proponents of national socialization. Medical service has flourished in this country because free enterprise provided, through the channels of personal incentive, for its growth.

The Christmastide is a time to look back over the years and their blessings. Certainly the freedom we have known in these United States is the greatest of all blessings, and from it has evolved the finest medical service in existence throughout the world today. As we look to the year ahead, let us resolve that it shall not mark the turning point towards regression through socialization, for a welfare state denies individuality, and without individuality there cannot be the personal incentive which is prerequisite to progress.



DR. ALFRED ELLISON

PRESIDENT-ELECT

DR. Alfred Ellison of South Bend was elected to the office of president-elect of the Indiana State Medical Association on September 29, 1949. In accordance with the change in by-laws which was adopted at the same meeting he assumed the duties of the office at the conclusion of the annual convention.

Doctor Ellison, at the time of his election, was completing his third year as chairman of the Council. Previous to this he was a member of the Council, representing the Thirteenth Council District from 1936 to 1949. He also served as secretary of his District Medical Society in 1934, and was president of the St. Joseph County Medical Society in 1943-44.



He entered Indiana University in 1914 and received the degree of Doctor of Medicine in 1924, after having spent eighteen months in military service in World War I. After a rotating internship at the Indianapolis City Hospital, he entered the general practice of medicine in South Bend. In 1930 he began a three-year postgraduate course in surgery, returning to South Bend in 1933 to enter the practice of general surgery. He is now chief of the surgical staff of the Memorial Hospital, South Bend.

Doctor Ellison is also at present a member of the advisory board of the State Welfare Committee, and a director of the Mutual Medical Insurance Company. He was a member of the Committee to Study Cultists and Irregular Practitioners from 1938 to 1943, and served as chairman of this committee from 1939 to 1943. He served on the Committee on Industrial Health in 1944, and on the Medical Relief Committee from 1944 to 1946. He has been a member of the Committee on Indiana Interprofessional Health Council for the past three years.

CENTENNIAL CONVENTION

THE 1949 Annual Convention of the Indiana State Medical Association commemorated the 100th anniversary of the Association's founding by attracting a total registration of 3,371. This exceeds by several hundred the largest previous annual meeting. More than half of the registrants were members of the association. They arrived 1,700 strong to welcome and entertain 1,287 guests. There were 384 exhibitors also in attendance.

The meeting was opened on Monday, September 26, with the technical, scientific and historical exhibits, and instructional courses for the scientifically-minded, and with the golf tournament and trap shoot for the athletically-inclined.

The thirty classes of the instructional course were exceptionally well attended; many of the courses were sellouts, and all were gifted with attentive and appreciative audiences.

The golf tournament was conducted at the Highland Golf and Country Club. Ninety-six golfers took advantage of perfect weather to make it one of the most successful meets ever held. Scores of valuable prizes were awarded. Dr. Ed Eaton, Indianapolis, led the contestants in the low gross classification, and Dr. C. O. McCormick, Sr., Indianapolis, won the banker's handicap.

The trap shoot was organized into three classes and had five full squads of shooters. Dr. Harold

Adkins, Indianapolis, was first in class A with a score of 98x100. Dr. Rollin Moser, Indianapolis, and Dr. C. W. Cullnane, Evansville, tied for first place in class B with scores of 92x100. Dr. Byron Nixon, Farmland, led class C with 84x100.

SCIENTIFIC PROGRAM

The full three-day scientific session was opened on Tuesday with the first of a series of televised surgical operations and medical clinics. A total of 26 clinics were transmitted from the Medical Center to the viewing screens in Murat Temple during the convention. This proved to be one of the most popular of all the convention activities and played to capacity audiences.

The scientific program at the general meetings served to bring together outstanding authorities from all over the United States. Fifteen guest essayists, all of whom were Hoosier-born or Hoosier-educated, combined with an outstanding group of our own members to present discussions on a wide variety of clinical subjects.

ENTERTAINMENT

The noon intermissions of the convention were utilized for numerous class reunions, fraternity get-togethers, special society meetings, and for a

luncheon meeting of the Indiana Academy of General Practice, which was addressed by Dr. Rufus B. Robins, Camden, Arkansas, member of the A.M.A. Coordinating Committee.

On Monday night the dinner meeting for women physicians and the stag party were highly successful affairs. On Tuesday evening the Baltimore and Ohio Glee Club entertained a capacity gathering in the Murat Theater. Wednesday night a similarly large audience enjoyed a musical program and an address by Dr. W. M. Krogman of the University of Pennsylvania.

The facilities of the Indiana Roof were strained on Thursday night by the attendance of 1,000 members, guests and their ladies at the Annual Banquet. The program for the evening included introduction of the many distinguished guests present, recognition of the 34 new members of the Fifty-Year Club, and presentation of the award to the General Practitioner of the Year, Dr. Charles Crampton of Delphi.

Response on behalf of those honored for having completed 50 years of practice was made by Dr. H. G. Weiss of Evansville. Doctor Weiss spoke of the satisfaction of having practiced during medicine's most progressive and fruitful half century, and assured his listeners that the newly inducted group were appreciative of being honored and expected to continue their work for many years to come.

HOUSE OF DELEGATES

The first session was devoted principally to reports of officers and standing committees. Reports and resolutions were referred to reference committees for study. Dr. Claude S. Black addressed the house in his capacity as president-elect. Dr. John Dalton, Indianapolis, presented to the association a portrait of Dr. Livingston Dunlap, who is generally credited with having been the leader of the organization of the state association, and who was chairman of its first convention.

Deliberations of the second session of delegates are condensed as follows:

Dr. Alfred Ellison, South Bend, was elected to the office of president-elect, and Dr. A. F.

Weyerbacher, Indianapolis, was re-elected as treasurer.

Dr. F. S. Crockett, Lafayette, and Dr. William Cockrum, Evansville, were elected for terms of two years to succeed themselves as delegates to the A.M.A.

Dr. A. M. Mitchell, Terre Haute, and Dr. Cleon A. Nafe, Indianapolis, were elected similarly as alternate delegates to the A.M.A.

Indianapolis was selected as the meeting place for the annual session in 1951. (French Lick will be host city in 1950.)

The House acted favorably on a recommendation to continue the Instructional Courses with each annual session.

A resolution favoring a three-year period in general practice as a prerequisite to specialty training was adopted.

A committee was authorized to study the problem of training laboratory technicians for physician's offices.

The publication of *ISMA News Flashes* by the Committee on Public Relations was commended.

Amendments were adopted for the By-Laws to change the terms of office for the president, president-elect, and the treasurer to the period between the termination of the annual sessions.

A resolution was adopted to urge the establishment of general practice residencies and internships.

The partial dues which are paid by newly elected members when membership begins after October 1, and the dues paid by interns and residents was changed from \$5.00 to \$10.00.

The regular dues were changed from \$15.00 to \$35.00.

A new office of assistant treasurer was created, and the Council was directed to appoint a member to this position, and to prescribe his duties.

The House of Delegates concluded its business by passing numerous resolutions of appreciation, chief among which were those expressing gratitude to Dr. Augustus P. Hauss, retiring president, for his untiring efforts to assure the success of the Centennial Convention.



SECRETARIES AND EDITORS CONFERENCE

THE Conference of State Medical Association Secretaries and Editors met in Chicago on November 3 and 4, 1949. The meeting was conducted under the auspices of the A.M.A., with discussions presented by national authorities on a wide variety of subjects.

Subjects such as "Office and Personnel Management," and "Radio Relations for State Medical Meetings," were presented for the secretaries. A few of the papers dealt with the details of publishing a medical journal. However, the great majority of the discussion was devoted to the subjects of general interest to the medical profession.

The "Medical Grand Jury" was described by Harvey T. Sethman, executive secretary of the Colorado State Medical Society. This is the common name for the Board of Supervisors of the Colorado Society which investigates complaints made by patients against practicing physicians. The board is empowered to take testimony and investigate fully into complaints and also may investigate on its own motion. Depending on the results of its findings it may dismiss or settle the complaint amicably, or may file charges for trial by the Judicial Council or by civil courts.

Dr. A. M. Mitchell, of Terre Haute, took part in a symposium on the coordination of four of the national meetings of special interest to officers of state and county medical societies. Doctor Mitchell described the founding of the conference for which he is justly famous, and for which he has served as chairman since its inception, The National Conference of County Medical Society Officers. Since the conference was originated to provide a medium of direct expression between the county societies and the A.M.A., Tom Hendricks dubbed it the "Grass Roots Conference," which name has remained with it ever since. Doctor Mitchell described the meeting as having not only fulfilled its primary purpose, but as also accomplishing a secondary objective of developing medical leaders and thereby bringing new blood into the national medical picture.

George W. Bachman, Research Senior Staff Member of the Brookings Institution, described the scope of a survey which the institution is undertaking to determine the availability and utilization of medical care in America. At present there is a great lack of factual information on this subject. Collection of information by an impartial fact-finding agency such as Brookings Institution will be of tremendous help in solving the nation's health problems. Doctor Bachman solicited the help and cooperation of the medical profession for the survey.

The conference was concluded by a report on The British National Health Service by John W.

McPherrin, New York, editor, *The American Druggist*. Mr. McPherrin traveled extensively in England and Scotland, interviewing citizens in all walks of life, as well as government officials. He described several of the people to whom he talked as expressing the opinion that they were pleased to be receiving medical care so reasonably, but that they did not relish having their children brought up under a socialistic system, as they felt that it was preventing them from obtaining for themselves any spirit of self-reliance. He found that most of the Britishers thought that the total cost of the service was paid by their personal contribution, whereas as a matter of fact the personal contributions met about one-sixth of the cost, the remainder being paid from general taxation.

A.M.A. PUBLIC RELATIONS CONFERENCE

THE second annual A.M.A. Public Relations Conference was held Saturday and Sunday, November 5 and 6, at the A.M.A. headquarters offices. Attended by representatives from all states, it was hailed by those in attendance as the finest program of its kind.

Max M. Hattaway, M.D., Louisiana, presiding during the opening session, pointed out that the profession could no longer ignore the importance of a complete public relations program. He stated that public relations is a broad term used to incorporate all the activities of the profession.

Donald B. Koonce, M.D., North Carolina, stated that the time has arrived for the medical profession to get out of its defensive position and place itself in the offensive, with constructive programs of medical care and education. "Physicians are public servants, and as such must answer to the public. We must be prepared to answer its questions, as the public is willing to be told but they want to know why. Physicians should actively engage in all civic activities and organizations, and fight for the maintenance of individual initiative and those things the profession thinks right. Many physicians dislike paying dues so that their state association offices may do a good piece of work; some seem to think that all the state office of their association is for is to conduct an annual session once a year. It is important that we sell our own profession, before we sell the public, as the public dislikes favored groups, and many think we as medical men are members of a favored group. We should not expect favors not extended to others," he concluded.

Percy E. Hopkins, M.D., Illinois, pointed out that it was important that all committees of the state association work closely together, and recommended that representatives of other committees be invited to sit in at the meetings of related com-

mittees so that a close understanding and working relationship could be developed.

Charles L. Farrell, M.D., Rhode Island, recommended that an able public relations chairman be appointed at the county level, who would act as spokesman for the society, with freedom to deal with public relations problems. The woman's auxiliary should also be included in every county and state public relations committee, he said.

A. E. Cardle, M.D., Minnesota, presiding at the afternoon session, pointed out that public relations is nothing but "good manners that should be practiced by every physician."

J. H. A. Peck, M.D., Kansas, told of the experience of his state in getting doctors into the rural areas. "Our state association has been and is working very closely with rural groups. We have encouraged and worked for additional money for medical education. We have counseled with areas requesting a doctor, and assisted in setting up small community hospitals and offices for physicians that were equipped with the tools that would make it worth-while for a doctor to practice in these communities. We have done everything possible to solve our own problem, and we have gone a long way. This is evidenced by the fact that we are having requests from premedic students from many other states, wanting to complete their training in our medical school and practice in the rural communities of Kansas. A willingness on the part of doctors and the public to work together is the factor that is making our program a success."

George H. Garrison, M.D., Oklahoma, explained the PR value of their grievance committee. "Our program has worked wonders in our state, and today we would not do without our grievance committee. Our association has done nothing that has proven more valuable to us 'public-relation-wise' than the formation of our committee, which is composed of the five living immediate past presidents. The public is interested in the medical profession if honestly and fairly served. Misunderstandings and abuses that are not corrected promptly destroy the faith of the public in the medical profession. The members' names of our committee are not a secret; these have been publicized along with information as to how a grievance should be filed. I am glad to report that in every case each complaint that has been made has been settled to the complete satisfaction of all. The press and radio have been extremely helpful, all this has created a new element of faith on the part of our public with the physicians of our state. If you do not have such a committee work-

ing in your state association I cannot recommend too highly that you immediately place such a committee into operation, but the committee must function, you cannot organize it in name only."

McKinnie Phelps, M.D., Colorado, stated that their state association had profited by establishing a code of understanding between members of press, radio and medical profession. "Under our plan we have a physician in each county society that is empowered to speak for the society. Names of these men are filed with every newspaper and radio station for their ready reference. Our society representatives help see that the information is accurate, and we encourage the release of news matter from our societies. Each year we sponsor a press and radio dinner, at which time we invite representatives of all newspapers and radio stations in to meet with us and discuss the means whereby we might improve our program."

C. Allen Payne, M.D., Michigan, explained how his state had worked with the Woman's Auxiliary in developing their public relations program. "The women of our state have accepted a major share of our public relations activities," he said. "Women get around more than their husbands and have an opportunity to carry out public relations activities that the physician has no time for due to his practice. Our auxiliary has accomplished an outstanding piece of work in interesting high school students in entering medical training, and training in fields allied to medicine. They have assisted in the community enrollment programs of our Blue Cross and Blue Shield Plans. They have been most valuable in carrying out nurse recruitment programs and have even raised funds for scholarships. They have collected medical equipment and supplies for hospitals and have placed the *JOURNAL* and *Hygeia* in the schools and libraries. Speaking teams have been organized on T.B. and other subjects. These teams have appeared in the schools throughout the state to talk to the students. A Health Month has been another of their projects. During this time they encourage and participate in meetings for the discussions of health subjects. They encourage and help in immunization work and assist all worth-while voluntary health agencies. Our auxiliary is active in hospital guilds, and has proved most helpful in our legislative programs. Last but not least, they have proved a most potent factor in our program of education against compulsory health insurance."

The meeting closed with a session Sunday morning devoted to the delegates getting their problems off their chests. This session had active participation by the delegates.



LOCKING SELF-RETAINING RETRACTOR

FRANKLIN E. HAGIE, M.D.

RICHMOND

THE Balfour self-retaining retractor, so universally used, is most convenient, but it has always had a tendency to creep at the friction joint during an operation, so that the lateral spread decreases. In order to correct this fault, in the last year or so the model has been changed and a ratchet has been incorporated on the proximal cross bar.

This article deals entirely with the thousands of the old type still in use, which almost regardless of age, are just as good as when purchased. This friction joint has been installed on other types of retractors, such as laminectomy and bladder retractors, and the correction for this creeping fault will apply to all types using this joint. In some hospitals gauze is used to tie the blade open so as to lessen the creeping, but we should have something better mechanically.

What I have devised and use on my retractors of this type is very simple, and any service man at the hospital, or you yourself can make the correction. On the proximal bar of the retractor I have drilled in the horizontal or axis of the retractor, $\frac{1}{8}$ inch holes $\frac{1}{2}$ inch apart, as shown in Cut No. 1 at A. Then with the blades separated to the desired size, I take a towel forceps, the Roeder or Backhaus type, which is curved most conveniently to lie under the bar and out of the way, and snap it into the hole on the cross bar corresponding to the spread and I have locked the blade, correcting any creeping tendency.

In Cut No. 2 you see the retractor with the towel forceps applied under the bar. It is very simple, nothing necessary to buy; drill the holes in the cross bar and you have a retractor, with the help of a towel forceps which is in every operative kit,

Figure 1

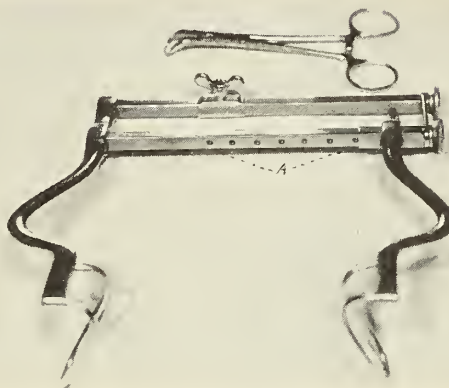
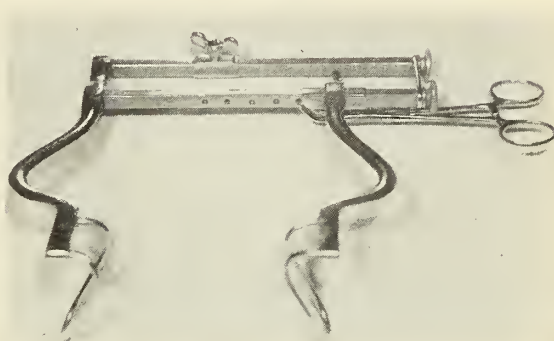


Figure 2



that keeps the same spread while you work. Because of the help the simple device gives I think it worthy of general interest to the surgeon and the hospital.

ATOM BOMB RADIATION OVERRATED

A PRACTICAL attitude toward the efficiency and limitations of the atomic bomb and its "mysterious" radiation is necessary "if we are to live with this piece of ordinance and ever have to use it again in the defense of our way of living."

This opinion is expressed by Colonel James P. Cooney, M.D., of the Atomic Energy Commission, Washington, writing in the July issue of *Radiology*, a journal devoted to clinical radiology and allied sciences. Colonel Cooney has been at the detonation of five atomic bombs, including the ones at Bikini and Eniwetok. He has interviewed and examined large numbers of the Japanese victims of such bombs.

"We must recognize that the casualties caused by the blast and burns from this weapon will be many times greater than the deaths caused by radiation," he says. "We must also dispel the erroneous idea that the rescue work of the injured will be impossible due to residual radiation. It is of the utmost importance that we recognize that the radiation hazards are additional hazards. They only add to the complexity and perhaps even the severity of the other hazards of total warfare. Therefore, we must not and cannot concentrate on this phase of atomic warfare to the detriment of other defensive preparations. Rather, we must

know and understand the facts about ionizing radiations if we are to survive the other dangers."

Colonel Cooney points out that it has been estimated that from 5 to 15 percent of the deaths at Hiroshima and Nagasaki were due to radiation. He adds that the atomic bomb was developed as a blast weapon of war and has been strategically so used.

"The radiation effect was never considered to be the prime component of its effectiveness," he says. "The destruction attendant upon the blast, heat and secondary fires was paramount. In Japan there was no significant 'poisoning' of the ground by fission products or induced activity from neutron capture; yet many believe that the bomb is primarily a weapon which destroys by mysterious radioactivity."

He says fire-fighting equipment is more important as a defense than Geiger counters.

"The residual radiation from an air burst bomb is insignificant," he adds. "The significant radiation occurs in a matter of microseconds and does not extend beyond a 2,000-yard radius. Immediately after a detonation such as occurred at Hiroshima or Nagasaki, it is perfectly safe to enter into a bombed area and rescue the thousands whose injuries will be such that they will not be able to walk."

"Unless evacuation of these injured is effected, thousands will be burned to death by secondary fires. Such was the case at Hiroshima and Nagasaki."

Colonel Cooney considers radiation "perhaps the most over-evaluated" hazard of war. He attributes this as due partly to the great care taken in "Operations Crossroads." Emphasizing that hazards acceptable in a peacetime operation cannot be adhered to in wartime, he adds:

"Psychological training for the military level of acceptable radiation hazard is possible and should be prosecuted, even though operation field training does not permit this to be accomplished at the present time.

"We hear much about sterility as a result of exposure to ionizing radiation. It must be borne in mind that this sterility results only from a large dose of acute radiation, or from smaller doses over a long period of time, a matter of years.

"Sterility also results from other accepted hazards encountered in war, notably venereal disease. We are aware of hundreds of paraplegias due to spinal fractures, gunshot wounds of the cord, et cetera, during the last war, resulting not only in sterility but impotence."

Colonel Cooney says that for battle discipline and military effectiveness the dominant measure is not the hazard itself but the soldier's estimation of the hazard. He cites what he called "unfortunate psychological reactions" in the minds of both the military and civilians which have developed since the advent of the atom bomb.

"This reaction is one of intense fear, directed against forces that cannot be seen, felt or otherwise sensed. I have observed the reactions of the military, who were not acquainted with the technical details, on two missions, Bikini and Eniwetok, and the fear reaction of the uninitiated is appalling.

"The fear reaction of the uninitiated civilian is ever evident. It is of such magnitude that it could well interfere with an important military mission in time of war."

An editorial in the same issue of *Radiology* discusses the problem of wartime radiation. The National Committee on Radiation Safety has fixed the 'permissible daily dose' of radiation at 0.1 roentgen a day and 0.3 roentgen a week. The journal cites the need for tempering this peacetime permit with the knowledge of man's ability to live through 100 roentgens (once).

"Unless they do learn this, they are likely to do all the wrong things in fear of the 'deadly' radiation in regions where it is in fact not deadly, and so lose their lives needlessly as a result of panic," says the editorial.

"For fighting men these lessons are even more acutely important, for there may arise occasions when voluntary exposure to radiation is necessary in order to gain military objectives.

"In war, therefore, where risks are part of the very fabric of life, radiation hazards should be measured in different quanta from what we use in peace. The roentgens should be parcelled out in sizes comparable to the other risks of the campaign."



Medical Panorama by the ASSOCIATE EDITOR

LET'S FIGURE A LITTLE

Along with the campaign for government medicine has gone the claim (or charge, if you will) that there is a serious shortage of physicians in the U. S. A., and it is even insinuated by some that the doctors themselves have put a limit on the professional supply for selfish reasons. Such statements and charges are of such concern that the following article by J. H. Lazzari, M.D., entitled "The Supply of Doctors," rates to be reprinted in full. It appeared in the *Bulletin of the Academy of Medicine of Cleveland*.

An editorial in the Plain Dealer of August 5, 1949 stated that the nation needed more doctors. The Plain Dealer states that 5606 men were graduated in 1905 and only 5543 in 1948. These actual figures are correct but the fallacies of the 1905 product do not appear. In any event, however, when our good newspaper believes a shortage of doctors exists, we ought to check the reasons for their opinion. The paper further states "If the medical profession really wants to deal a body blow to the agitation for a government health program, its first duty would seem to be to produce sufficient qualified medical personnel to do the job."

After all it is our duty to provide adequate medical care and if more physicians are needed we should produce them. There are sufficient statistics available for anyone to study but conclusions are difficult to draw. As will be shown below, we have increased the production of physicians and we would like to determine in some manner if the increment of increase has been sufficient.

The "demand" or "need" for medical care is difficult to estimate. The report on "The Issue of Compulsory Health Insurance" published by the Brookings Institution elaborates on the differences between "demand" and "need" for medical care. These differences are probably clear enough to most of us. It is clear that under any system of complete health insurance, many more physicians and dentists would be needed. The United States Public Health Service estimates that there would be a shortage of 30,000 physicians if the proposed hospital and medical care program is carried forward.

On our present basis of medical care there appears to be some shortage of physicians, but the actual number is not easy to determine. The citation of numbers of doctors is not a good criterion. Those who contend there is a shortage select the states with the highest concentration of physicians as an ideal level—in which there are 150 doctors per 100,000. One to 1500 was the accepted wartime standard for minimum civilian safety. Lee and Jones in 1933 ("The Fundamentals of Good Medical Care") considered the number of doctors for adequate prevention, diagnosis, and treatment to be one

to 742 persons. Our present ratio is about one to 760 and it has been estimated that by 1960 it will be one to 720. This appears adequate, assuming no striking changes in our pattern of medical care.

What have we actually done and what we are doing? In our analysis we must throw out the statistics of the 1905 period, an era of little pride in medical education. During the 10 years preceding the war, the average number of freshmen annually entering medical school was 6016. The 1948 entering class of 6688 was the largest in the history of our medical schools. The 1949 class will number about 6900 and future classes will exceed 7000. This is an addition of 1000 men annually entering our schools. The total number of students in our 78 medical schools will approximate 24,000, which is considerably more than the 21,597 of 1930 (although still less than the 26,000 of 1905). Graduates during 1948 numbered 5543, but graduate numbers have been disturbed somewhat by the change over from the accelerated to normal programs. It is obvious that graduates will soon exceed 6000 annually. The present senior class at Western Reserve numbers 91 students, larger than any previous senior class. The expansion of our medical teaching then is very definite. How much further it should proceed may be possible to determine soon.

The accelerated program of the war added a significant increment of extra physicians but these have not appeared on the consumer market because a majority of these men are still in federal services or in hospital training programs. Whereas in 1941 there were 5256 residents in civilian hospitals, there are now over 15,000 residents in various specialty training programs. As these men begin to leave hospitals and enter practice, the process will continue annually and we will have added 10,000 doctors to the nation's total. These men have been temporarily absorbed into our extensive resident training program which has been tremendously augmented by the war and the many specialty boards.

There appears no simple solution to the geographical distribution of doctors. This may not be as bad as some might have us believe. That there were 79 counties in 20 states with no physician may not be too serious. The county is not a suitable area unit for the determination of availability of medical care. We all admit that there are many areas which need physicians but it is not as easy to be a "pioneer" doctor today as it was in 1910 and it is very natural that the graduate of today prefers to settle in areas which provide tools for modern practice. Air transportation will solve more and more of these problems for medicine as it is doing for so many phases of our social and economic life.

"The laws of supply and demand can solve all the issues involved but the process is slow and the excessive swings of the pendulum are undesirable. The application of intelligent control based on sound analysis can be of considerable aid."

The Fourth Estate Looks At Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

THE POLICE STATE

Has the police state come to this country? Of course not. It couldn't happen here, or could it?

Maybe it is just a coincidence that the anti-trust division of the Department of Justice is investigating the American Medical Association and 16 other state and county medical societies.

Somebody broke into the board room of the trustees of the American Medical Association in Chicago last February and ransacked the records. That couldn't have been anyone connected with the government, else why would the FBI be going through the records now? The trustees of the association have revealed that the FBI wants to see all records going back to 1938 and copies of all speeches made by A.M.A. officials since then.

It happens, however, that the American Medical Association is conducting a nation-wide campaign against President Truman's compulsory health insurance program. In a police state, when anybody opposes the government, the police move in and cart the objectors off to jail.

That hasn't happened here—yet. The federal police have moved in, but they haven't carted anybody off to jail—yet.

Maybe the suspicions of the Department of Justice are well founded. The FBI may find evidence that the medical association has been violating the antitrust laws because it restricts its membership to those who conform to certain standards and who have passed examinations conducted by state boards. If so, then the FBI might also find that bar associations, dental societies, professional engineers, barbers, cosmetologists and all other organizations whose members are licensed by the states also were in violation of the antitrust laws.

Could it be that the Department of Justice is trying to get something on the American Medical Association because it is leading the fight against socialized medicine? What a ridiculous idea! President Truman and Attorney General McGrath wouldn't allow our government to employ police state methods, or would they?

Cleveland Plain Dealer

THE DOCTORS AND 'ALLEY FIGHTING'

The issue of state medicine is so important, says President Ernest E. Irons of the American Medical Association, that doctors should resort to "alley fighting," if that seems necessary.

Dr. Irons is here giving the doctors very poor advice. If the medical profession cannot lick state medicine by the weight of the evidence, it cannot lick it by wrangling and a show of force. In fact, resort to such tactics is sure to be interpreted as proof that the valid arguments are all on the other side.

A good, practical case can now be made against state medicine by publicizing its effects in countries where it is practiced. A speaker at the A.M.A. convention—a former British doctor—has told the delegates how poorly the system works in England. He spoke of the myriad of forms, the overcrowded waiting rooms, the few minutes that can be given each patient, the interminable delays in getting special treatment and surgery.

Surely with such evidence available, it would be a mistaken policy to resort to alley fighting, just as it has been a mistaken policy to talk so much about the effect of compulsory health insurance on the medical profession, rather than its effect on the patient.

While it is true that medical care in this country is on the whole superior to medical care elsewhere, it is also true that good medical care is still lacking in some areas and for some people in all areas. That is a problem which we must face. If state medicine is not the answer (and it isn't), then the real answer must be found. The A.M.A. should want to help not only in defeating plans for state medicine here but also in providing a better substitute.

To do this will require a campaign on the highest and most unselfish level. An alley fight will only bring into question the motives of the doctors, which have already been questioned by the advocates of state medicine.

Milwaukee Journal

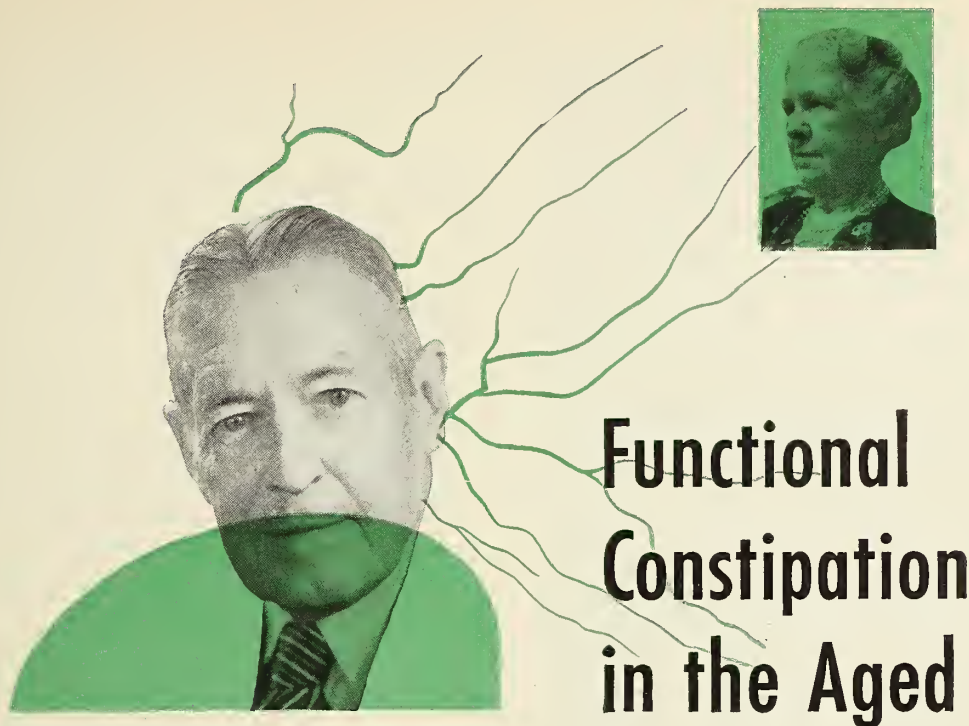
BELCHER'S LAW OF WELFARE DYNAMICS

In galloping through a business analysis by Paul E. Belcher, published by the First National Bank, of Akron, Ohio, we ran into a sentence which ought to go places:

"The trend toward a welfare state . . . will end whenever more than half the voters are required to pay for benefits they themselves do not get."

This statement ought to be dignified as Belcher's Law and be put into textbooks on economics. We are now in the phase where the good shepherds of the welfare state hope to keep the majority contented by extracting the bulk of the dough from the minority. When the minority runs out of funds, the test of Belcher's Law will be at hand.

Saturday Evening Post



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*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.



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News Notes

CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

The Sixth National Conference of County Medical Society Officers will be held in Washington, D. C., during the Clinical Session of the A.M.A. The meeting is scheduled for December 8 at 8:00 p.m. in the Hotel Statler. All doctors and their wives are invited to attend.

PROGRAM

COMMUNITY HEALTH LEADERSHIP

Outstanding Local Achievements

The Miracle of Flint.....A. L. Tuuri, M.D., Medical Director, Mott Children's Center, Flint, Michigan.
Erie County Rings the Bell.....Roy L. Scott, M.D., President, Medical Society, County of Erie, Buffalo, New York.

National Programs Depend on Local Achievements

The American Legion's Community Development Program.....George N. Craig, National Commander, The American Legion, Brazil, Indiana.
The Program of the United Mine Workers.....Warren F. Draper, M.D., Executive Medical Officer, Welfare and Retirement Fund, U. M. W. of America, Washington, D. C.
The Doctor's Prognosis.....Joseph Wall, M.D., Past President, Medical Society, District of Columbia, Washington, D. C.

Here is a program that should be of interest not only to every medical society officer but also to every member. Community Health Leadership—the cooperation of doctors and laymen where it is needed most and can accomplish the most—is the theme.

CARE PROGRAM SENDS MEDICAL BOOKS ABROAD

To supply the latest medical and other scientific knowledge for professional people and students overseas, CARE, in cooperation with UNESCO, has added a book program to its food and textile package service.

Under the plan, endorsed by the American Medical Association, CARE and UNESCO representatives in Europe and Asia are obtaining lists of the book needs in specified scientific and technical categories from war-wrecked universities and libraries abroad. With the funds contributed by Americans, CARE then fills those needs as closely as possible by purchasing the latest and best books in those fields published in English.

Contributions in any amount can be sent to the CARE Book Program, 20 Broad Street, New York 5, N. Y., or to any CARE office in the country. Donations under \$10 are pooled in a general fund. Donors of \$10 or more can specify the institution, country and category (such as medical) book to be sent. They receive a receipt signed by the recipient on delivery, so that they know exactly where, and to whom, their gift has gone. On undesignated orders, CARE will select recipients on the basis of greatest need.

RURAL HEALTH CONFERENCE

The fifth National Conference on Rural Health will be held in Kansas City, Missouri, February 3-4. Dr. F. S. Crockett of Lafayette, is chairman of the Committee on Rural Health of the American Medical Association, which is sponsoring the meeting.

Discussion subjects will include: Rural medical facilities at local levels; the relation of agricultural extension service to rural health problems; community responsibility for health service in rural areas; methods of prepayment for health services in rural areas, and the responsibility of the medical schools in the rural health program.

BLOOD BANK SURVEY

The American Medical Association is conducting a nationwide survey of blood bank resources. Under the direction of a special committee established by the A.M.A. House of Delegates, the A.M.A. Bureau of Medical Economic Research has just completed mailing questionnaires to more than 1,500 blood banks and 5,100 hospitals which have no blood banks.

Dr. George F. Lull, of Chicago, general manager of the A.M.A., said that the questionnaires are the first step in determining the capacity, equipment, personnel, inventory, general processing procedures, and arrangements for emergency cooperation among blood banks.

HILL-BURTON ACT AMENDED

The prospect for new hospitals and for research leading to improved services in existing hospitals have been enhanced by amendments to the Hospital Survey and Construction Act. The amendments, doubling the amount of Federal funds which will be made available to the states and liberalizing the amount of the Federal contributions, became effective October 25, when they were signed by President Truman.

Under the terms of the new legislation, the amount of Federal grants to the states is increased from \$75 to \$150 millions annually, and the period during which allotments can be made is extended from June 30, 1950, to June 30, 1955. In addition, a new formula has been developed which permits a Federal contribution ranging up to 66.6 percent of the total construction costs for new hospitals as against a contribution of 33.3 percent under the original law.

The new legislation provides also for Federal grants totaling \$1,200,000 a year for five years for research programs looking toward coordination and improvement of hospital services.

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Henderson New President-Elect of World Medical Association. Dr. Elmer Henderson, Louisville, president-elect of the American Medical Association, was distinctly honored recently when delegates from 30 countries selected him as president-elect of the World Medical Association at the Third General Assembly, held in London.

Dr. Henderson will take over the A.M.A. presidency at the San Francisco session in June, and the presidency of the World Medical Association when the assembly meets in New York in October.

Dr. R. L. Sensenich, South Bend, past-president of the A.M.A., was elected to succeed Dr. Henderson as a member of the Council of the World Medical Association.

AMVETS, (the American Veterans of World War II) in national convention at Des Moines, Iowa, on September 5, adopted a strong resolution against any form of Compulsory Health Insurance. AMVETS is the third great national servicemen's organization to take official action against regimentation of the medical profession within the past two weeks. At the recent National Convention in Philadelphia, the American Legion and Auxiliary reaffirmed their position against any form of compulsory health insurance, and the Veterans of Foreign Wars took similar action at its recent meeting in Miami.

NEW ARMY PLAN TO CONSERVE MEDICAL AND DENTAL SKILLS

A newly-adopted Department of the Army plan will result in greater economy in the use of scarce professional personnel in military hospitals in theaters of operations, according to an announcement by Major General R. W. Bliss, the Army Surgeon General.

"Under this plan," said General Bliss, "fewer physicians or dentists will be ordered to active duty with Army medical units until those units are ready to move into a theater of operations. This should allow each doctor to remain in active practice in his community until the Army has an actual need for his services with troops in combat."

Hospital personnel will now be divided into two groups—administrative and professional personnel. The professional group will not be required to join the unit until such time as the unit is engaged in the actual care of patients. Further, when the requirement for this group has ceased, they may be moved to another theater of operations, or to another area within a theater where their professional services will be put to use with a minimum of delay.

Out of the 47 professional people required for a type of field hospital, under the new plan, only four officers would be required at all times for duty with the unit. The remaining 43 officers would not be needed during the organization and training period of the unit.

A special clinical meeting of the **Alembert Winthrop Brayton Skin and Cancer Foundation** will be held December 16, at Indianapolis General Hospital, with Dr. Francis Senear, of Chicago, as guest speaker. A discussion and showing of cases will be held in the morning, at the hospital, followed by a luncheon, and at 8:00 p.m., the Annual Brayton Foundation Lecture will be delivered before the Seminar of the Medical Faculty of Indiana University, in the auditorium of Indiana University School of Medicine.

A **National Conference on Cardiovascular Diseases** will be held in Washington, D. C., January 18-20, 1950, under the joint sponsorship of the American Heart Association and the National Heart Institute of the U. S. Public Health Service. This will be the first national conference bringing together physicians, scientists, community service leaders, and members of allied professions to formulate a comprehensive program to combat the nation's leading cause of death.

A two-day sectional meeting of the **American College of Surgeons** is to be held at the Brown Hotel, Louisville, Kentucky, on February 20 and 21. This meeting will consist of all day and evening conferences on timely surgical subjects and separate meetings for hospital personnel where hospital problems will be considered at panels and round table discussions.

The surgical program will include some new surgical motion picture films, papers and panels on such subjects as: Arterial Lesions of the Extremities, Hormone Therapy in Breast Lesions, Intestinal Obstruction, Gastric and Intestinal Intubation, Treatment of Head Injuries, Surgery of the Hand, Surgical Lesions of the Stomach, Cesarean Section, Management of Uterine Prolapse, the Management of Traumatic Conditions and a Symposium on Cancer.

Members of the Indiana State Medical Association and personnel of Indiana Hospitals are invited to attend this meeting. The fellows of the College in Louisville wish to assure all visitors that adequate hotel accommodations will be available and that they will be made most welcome at all of the sessions.

Seventeen persons from the United States and Canada have been named recipients of fellowships awarded jointly by Alpha Gamma Delta, international women's fraternity, and the National Society for Crippled Children and Adults, to attend a special training course for employment and placement counselors working with the cerebral palsied and other severely handicapped persons. Among those receiving fellowships was Mrs. Vida Davison, 2030 N. Delaware Street, Indianapolis, psychologist, Indiana Department of Public Welfare, Division of Crippled Children.

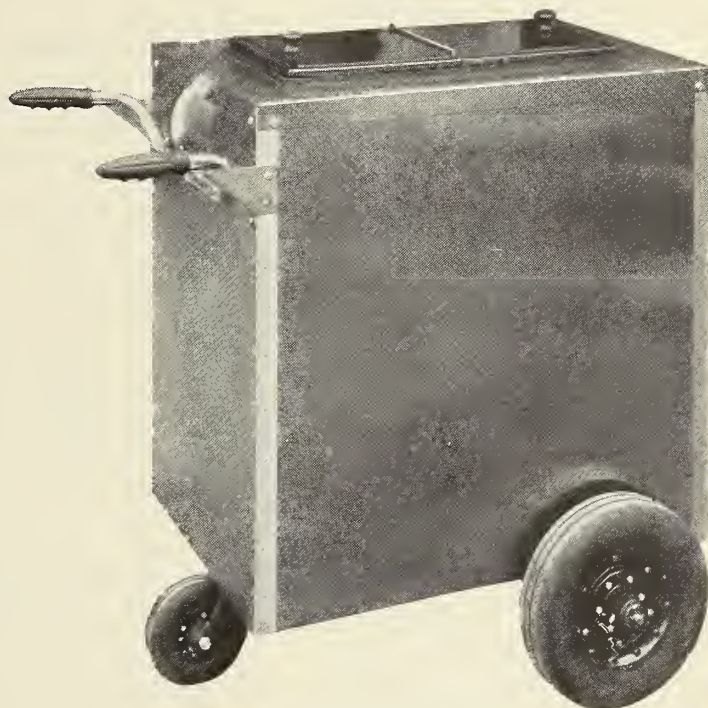
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INDIANA

Dr. Alan Willner, of Brooklyn, New York, has located in Clarksville for the practice of medicine. He is a graduate of the University of Louisville, and had two years of training at Syracuse University Medical Center.

Dr. Charles Weaver, of Greensburg, has been appointed to the staff of the Muscatatuck State Colony at Butlerville.

Announcement has been made by Dr. M. Hunter Smith of the opening of his office for the general practice of medicine and surgery at Goodland. A 1944 graduate of Indiana University School of Medicine, Doctor Smith served his internship at St. Elizabeth Hospital in Lafayette, and served a residency at St. Anne's Maternity Hospital in Cleveland. He entered the Navy in 1945, and was stationed at the U.S.N. Dispensary in Cleveland. He has been practicing general medicine at the Arnett Clinic in Lafayette for the past six months. Prior to that he was a staff member of the Purdue Student Health Service, following his discharge from the Navy in 1946.

HIGHER PAY APPROVED FOR ARMY PHYSICIANS AND DENTISTS

The effect of the recently passed Career Compensation Act of 1949 on the income of medical and dental officers has been analyzed by Major General R. W. Bliss, Surgeon General of the Army. He pointed out that a physician who has completed his internship, or a graduate dentist, may be commissioned as a first lieutenant, either in the Regular Army or in the Medical or Dental Corps Reserve, and now receive total pay and emoluments amounting to \$473.88 a month (if married or with dependents), or \$458.88 a month (if single and without dependents). These figures compare with former pay totals of \$417 and \$361, respectively.

A physician or dentist who has acquired sufficient professional experience, and who can meet the other requirements, may be commissioned directly as a captain or higher. A captain's pay, with emoluments, in the Medical and Dental Corps, is now \$546 (with dependents) or \$531 (without dependents), as against \$462 and \$426, respectively. On completion of four years of service, a captain receives regular increases at two-year intervals.

Comparable increases have been made in the higher grades, thus making the financial rewards of military service more commensurate with those of private practice.

Dr. William H. Davis, who has been practicing in Mount Vernon since July, has moved to New Market, where he has established an office.

Dr. Harold Manifold, of Muncie, has moved to Fortville to begin the practice of medicine in that community.

Dr. Charles H. Maly, who has been with the VA hospital in Indianapolis, has moved to Sardinia, Ohio, to begin practice there.

Dr. Elden J. Teeter, of Indianapolis, is now in practice in Goodland, Kansas.

A 1947 graduate of the Indiana University School of Medicine, Dr. Russell A. Eckert is taking a three-year residency in radiology at the Illinois Masonic Hospital, in Chicago.

Discharged from the service just recently, Dr. Thad T. Richardson, of Indianapolis, has opened an office in Portland for the general practice of medicine.

Dr. Stephen C. Bradley, of Terre Haute, was recently elected a Fellow of the American Academy of Pediatrics.

Dr. Robert F. Beuhl, of Indianapolis, has accepted the position of clinical director at the Madison State Hospital.

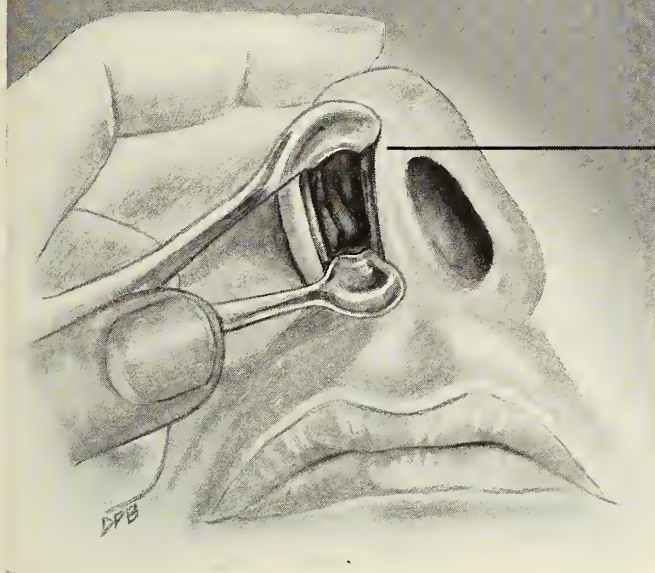
ANNUAL CLINICAL CONFERENCE A HIGHLIGHT OF THE CENTENNIAL YEAR OF THE CHICAGO MEDICAL SOCIETY

Attendance at the 1950 Clinical Conference of the Chicago Medical Society should be a MUST on your schedule. Set aside four days—February 28, March 1, 2, and 3, 1950, for valuable postgraduate observations in the great medical center of Chicago.

There will be clinical sessions and scientific lectures by the nation's foremost medical authorities and educators. There will be selected scientific and technical exhibits, displays that will dramatize medical developments "up-to-date." There will be color television of actual surgical procedures, and also black and white telecasts. Observers will see close-up surgical techniques and medical procedures in full color detail. There will be entertainment. The conference dinner will highlight speakers and entertainers.

Mark your calendar now for February 28, March 1, 2, and 3, and make your reservation direct to the Palmer House which will be the headquarters for this great 1950 meeting.

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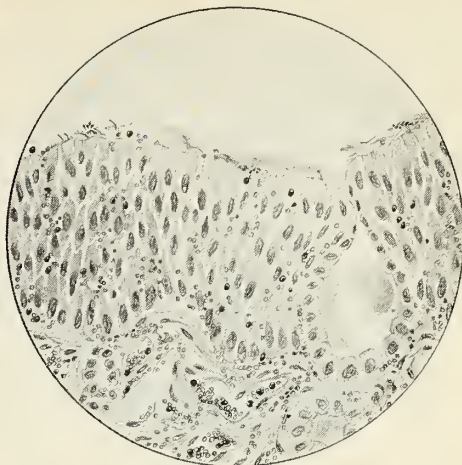
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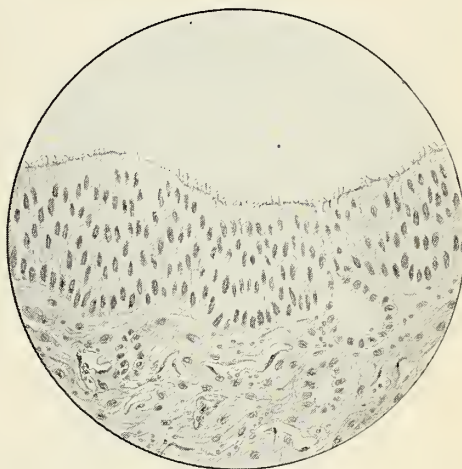
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Dr. Lawrence Shinabery, of Fort Wayne, was named president-elect of the Association of American Physicians and Surgeons at the organization's annual meeting in Detroit recently. He will assume the presidency in October 1950. Doctor Shinabery has been treasurer of this organization for two years.

Nine hundred and twenty-one initiates were received into fellowship at the convocation of the American College of Surgeons on October 21, in Chicago. Physicians from Indiana who became fellows are: James A. Work, Jr., Elkhart; Maurice I. Marks, Fort Benjamin Harrison; Warren C. Hastings, John J. Lehner and Cecil G. McEachern, Fort Wayne; V. Earle Wiseman, Greencastle; Joseph R. Eastman, Jr., Harris B. Shumacker, Jr., Carl B. Spath, Jr., Frank W. Teague, John V. Thompson, and Julius C. Travis, Indianapolis; Joseph B. Davis, Marion; Wendell E. Covalt, Muncie; Morris S. Friedman and Carl J. Langenbahn, South Bend.

The Wells County Medical Society conducted its third Annual Fall Clinical Conference at Bluffton on October 12. Seventy-four physicians attended the meeting, which devoted the afternoon and evening to the delivery of clinical papers and discussion.

The Division of Nursing Education, School of Education, Indiana University, has announced the addition of three new members to their faculty. Miss Myrtle E. Lewis will be instructor in obstetrical nursing; Miss E. Rita Davidson will be instructor in pediatric nursing; Miss Catherina B. Glennon will be instructor in nursing education, and will also be coordinator of field work in public health nursing.

The next written examination and review of case histories (Part I) of the American Board of Obstetrics and Gynecology, Inc., for all candidates will be held in various cities of the United States and Canada on Friday, February 3, 1950. Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held May 21 to 28 inclusive, 1950, at The Shelburne, Atlantic City, New Jersey. Notice of the exact time and place of the Part I and Part II examinations will be sent all candidates well in advance of the examination date.

Application forms and Bulletins are sent upon request made to Paul Titus, M.D., Secretary-Treasurer, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

Dr. Kenneth L. Craft, of Indianapolis, was elected second vice-president of the American Academy of Ophthalmology and Otolaryngology at its 54th annual meeting in October. Doctor Craft's term of office will be for the calendar year of 1950.

The November issue of *Harper's* magazine carries the first installment of a two-part article by Milton Mayer, entitled "The Rise and Fall of Doctor Fishbein." The author's analysis and comments about Doctor Fishbein's career are most interesting. The article is recommended to physicians for their general information.

The second annual Conference on Physicians and Schools, sponsored by the A.M.A., held a three-day meeting at Highland Park, Illinois, October 13 to 15. The following were registered from Indiana: B. N. Lingeman, M.D., Crawfordsville, Indiana State Medical Association; Randel Shake, Indianapolis, American Legion—Child Health; Ray E. Smith, Indianapolis, Indiana State Medical Association; Robert Yoho, Indianapolis, Indiana State Board of Health and State Board of Education, and Willard W. Patty, Bloomington, Indiana University.

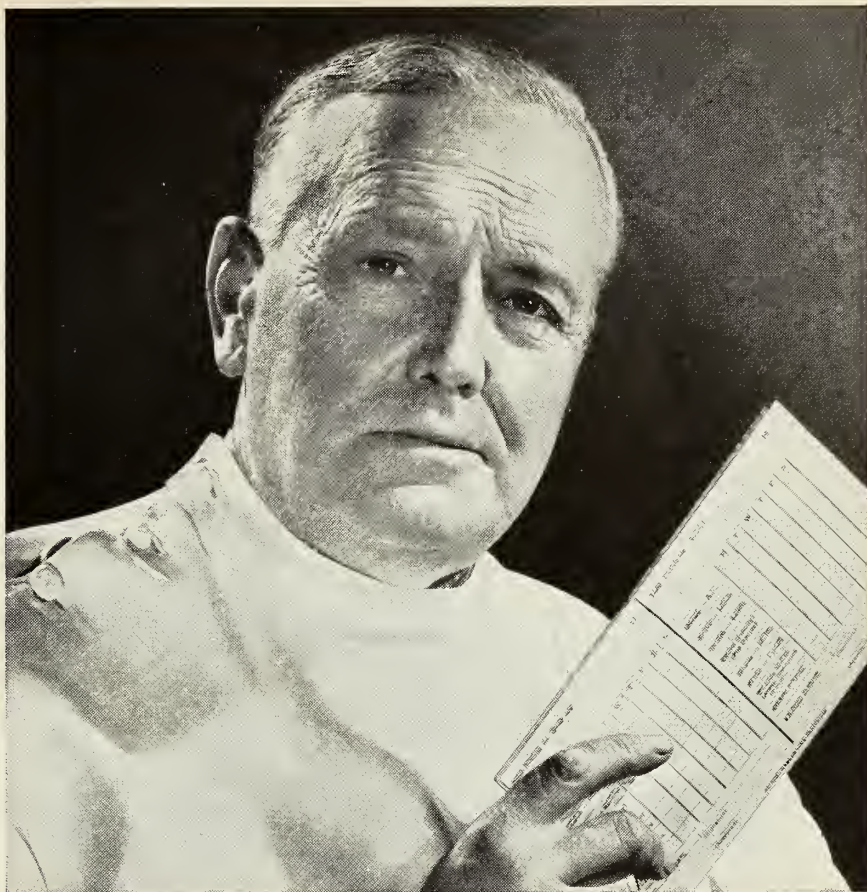
The following is from Secretary's Letter, from the office of Dr. George F. Lull, Secretary and General Manager of the A.M.A.:

Attention Private Secretaries! The next time your physician-boss receives any mail from the A.M.A., please don't toss it in the waste basket; make sure the doctor gets it.

I bring this to your attention because of an incident at a small private dinner party a few nights ago. There were five outstanding medical men and their wives from various parts of the country present, and one of the ladies remarked that she read the wonderful A.M.A. article in "Look" magazine in a beauty shop while waiting for her hair to dry. She said she didn't know the article was coming out and, worse still, none of the five doctors had even heard of it.

This is all a bit exasperating since the A.M.A. spent more than \$2,500 to promote the article before it appeared on the newsstands September 27. Post cards, calling the doctors attention to "a comprehensive six-page feature entitled 'What is the A.M.A.?', " were mailed to more than 177,000 physicians. We thought every doctor would know about the article as a result of this huge mailing, but, judging from the comments of the five at the dinner party, the cards never reached their desks.

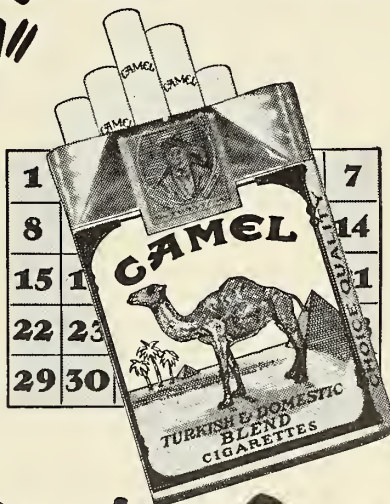
Can all the blame be placed on the poor secretaries? We don't know exactly, but we enlist your help in seeing hereafter that your doctor-boss gets a chance to see the mail he receives from A.M.A. headquarters.



*Throat Specialists
report on
30-Day Test of
Camel smokers—*

**"Not one single case of throat irritation
due to smoking Camels!"**

● Yes, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast to coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!



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Winston-Salem,
N. C.

According to a Nationwide survey:

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than any other cigarette!**

Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

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Dr. Wallace Childs has announced his association in the practice of radiology with his father, Dr. A. G. W. Childs, in Madison. Dr. Wallace Childs spent five years in the Army, and then spent two years at Hines Hospital in Chicago, and one year at the Indiana University Medical Center, preparing for his specialty.

Dr. J. H. Purcell, of Winslow, has moved to Boonville, where he has taken over the practice of Dr. I. L. Faith, who moved to Newburgh. Doctor Purcell is a 1947 graduate of Indiana University School of Medicine, interned in Gary, and took postgraduate work at the University of Illinois.

Dr. Arvin Henderson, of Ridgeville, has announced that Dr. R. C. Steck, physician and surgeon of Toledo, Illinois, is associated in practice with him. Doctor Steck is a 1942 graduate of the University of Illinois Medical School, and has done postgraduate work at the Universities of Illinois and Minnesota, and Cook County Hospital, in Chicago.

Dr. Alvin L. Henry has opened an office in Columbus for the practice of ophthalmology. A 1944 graduate of Indiana University School of Medicine, he completed a residency at Indianapolis General Hospital in October. Doctor Henry is an Army veteran, with more than two years of service.

On December first Dr. Louis Blessinger, of Huntingburg, took over offices and practice of Drs. John Gwinn and August Yochem, in Corydon. Doctor Gwinn has a three-year fellowship in pediatrics at the Mayo Clinic, and Doctor Yochem has a three-year residency in neuro-psychiatry at the Indiana University Medical Center. Doctor Blessinger is a graduate of the Indiana University School of Medicine, and has been in practice in Huntington for the past eighteen months. Both Doctor Gwinn and Doctor Yochem are graduates of the University of Louisville School of Medicine, and they have been practicing in Corydon since January 1948.

Deaths

William Francis Healy, M.D., of Evansville, died on October 7, in Philadelphia, Pennsylvania. He was forty-five years of age. He was a native of Indianapolis, and graduated from the Indiana University School of Medicine in 1929. Doctor Healy was a member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Stephen B. Sims, M.D., of Frankfort, died suddenly on October 13, at the age of eighty-eight. He graduated from Rush Medical College in Chicago in 1884, and had practiced in Frankfort for more than sixty years. He retired three years ago. Doctor Sims was an honorary member of the Clinton County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Lewis Eli Stephenson, M.D., of Michigan City, died suddenly on October 24. He was seventy years of age. He graduated from the Medical College of Indiana, in Indianapolis, in 1905, and had practiced

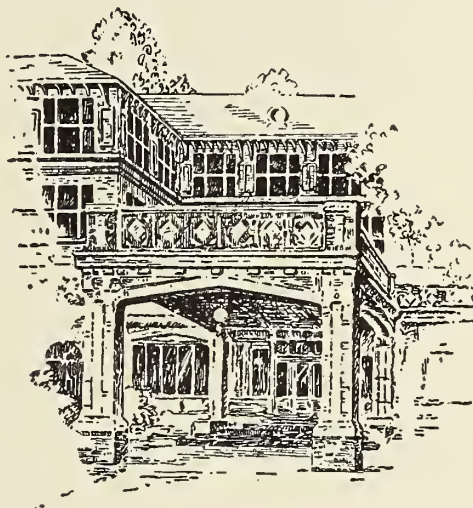
in Michigan City for twenty-three years. He was a member of the LaPorte County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Stephen W. Stuteville, M.D., retired physician of Grandview, died on September 30, at the age of seventy-seven. He was a graduate of the University of Louisville School of Medicine, in 1893, and had practiced in Spencer County for fifty years.

Emory E. Holland, M.D., of Richmond, died on October 13, at the age of sixty-five. A graduate of Indiana University School of Medicine in 1909, he had practiced in Richmond for thirty-three years. Prior to establishing a practice in Richmond, he had practiced in Texas. Doctor Holland was a member of the Wayne-Union County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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J. H. GRIMES, M.D., *Assistant Director*

L. M. HUGHES, M.D., *Assistant Director*

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

October 30, 1949

Roll call showed the following present: C. H. McCaskey, M.D., chairman; W. L. Portteus, M.D.; C. S. Black, M.D.; Alfred Ellison, M.D.; W. U. Kennedy, M.D.

Frank B. Ramsey, M.D., editor of *THE JOURNAL*; Albert Stump, attorney; Ray E. Smith, and J. A. Waggener.

Guests: Cleon A. Nafe, M.D., chairman, Indiana A.M.A. Campaign Coordinating Committee; E. M. Dill, D.D.S., administrator, and Maurice Hunt, head of the Public Assistance Division, State Department of Public Welfare.

Membership Report

Number of members October 26, 1949	3,718*
Number of members October 26, 1948	3,661
Gain over last year	57
Number of members December 31, 1948	3,689
* Includes 36 in military service (gratis)	
189 honorary members	

Treasurer's Office

On motion of Drs. Kennedy and Black, the treasurer was authorized to sell whatever securities necessary to secure cash for the \$23,000.00 appropriated by the Council to the Indiana A.M.A. Campaign Coordinating Committee.

Indiana A.M.A. Campaign Coordinating Committee

The chairman of this committee reported on the activities of the committee and its plans for 1950.

Statements of receipts and expenditures for September for the association and *THE JOURNAL* were approved.

1949 Annual Session, Indianapolis, September 26-29, 1949

Convention expenses. On motion of Drs. Black and Portteus the committee voted that all annual convention expenses shall be paid by check from the state headquarters office after approval by the Executive Committee.

Preservation of centennial information. Action on the proposal to preserve centennial information and data in a safety box, to be opened in 1999 or 2049, as recommended by the immediate past president, was postponed, on motion of Drs. Kennedy and Ellison, pending an estimate of the cost to be submitted by the past president.

1950 Annual Session, French Lick

Duration. On motion of Drs. Ellison and Portteus, the committee voted to have the 1950 annual session of three days' duration.

Dates. Monday, Tuesday and Wednesday, September 25, 26 and 27, 1950, were set for the meeting, on motion of Drs. Black and Kennedy.

Scientific exhibit. Decision on whether or not to have a scientific exhibit at the 1950 annual session was deferred until the next meeting, when the chairman of the Committee on Scientific Exhibit is to be present.

Organization Matters

State Chamber of Commerce membership. On motion of Drs. Ellison and Kennedy, the committee voted to take membership in the Indiana State Chamber of Commerce for 1949-1950.

Rural health survey. Action upon the request of the head of the Department of Agricultural Economics, Purdue University, for approval of a research project on "The Health and Medical Care Practices of Rural Families in Indiana" was postponed until the next meeting, at which time a representative of the department is to be invited to explain the project. The executive secretary was directed to write to the chairman of the A.M.A. Committee on Rural Medical Care for his opinion on the proposed project.

Medical assistance program. Dr. E. M. Dill, administrator, and Mr. Maurice Hunt, head of the Public Assistance Division of the State Department of Public Welfare, appeared before the committee and discussed medical problems of the Department of Public Welfare, after which the committee instructed the secretary, on motion of Drs. Portteus and Black, to notify the county medical societies to work closely with the medical advisory committee to their county welfare department. On motion of Drs. Portteus and Black, the committee recommended that the State Department of Public Welfare make a report to the Grievance Committee whenever alleged unethical medical practices are discovered. The suggestion was made that the Grievance Committee be directed to contact the county medical society and request that the county society investigate complaints against its members.

An appropriation of \$100.00 was voted for the use of the Grievance Committee for the balance of 1949, on motion of Drs. Ellison and Portteus.

Letter from Dr. J. William Wright, recommending a public relations counselor, was referred to the Indiana A.M.A. Campaign Coordinating Committee by consent.

National medical meetings. On motion of Drs. Ellison and Black, any person attending a national meeting as a representative of the Indiana State Medical Association shall prepare a report of the meeting for publication in *THE JOURNAL*.

The field secretary was authorized to attend the A.M.A. Clinical Session in Washington, D. C., December 6 to 9, 1949, on the motion of Drs. Black and Portteus.

1950 Medicine of the Year. An invitation for the association to participate in the distribution of the 1950 issue of *MEDICINE OF THE YEAR* was rejected by consent.

The Journal

Report on advertising:

Increases to October 25, 1949	\$186.20
Total increase for year	\$4,468.05

On motion of Drs. Portteus and Kennedy, the treasurer was directed to transfer \$3,000.00 from the General Fund to *THE JOURNAL* Fund.

Beginning January 1, 1950, payment of part of the executive secretary's salary from *THE JOURNAL* budget is to be discontinued, on motion of Drs. Ellison and Portteus.

There being no further business, the Executive Committee adjourned to meet again at 6:30 p.m., Saturday, December 10, 1949, at the Columbia Club.



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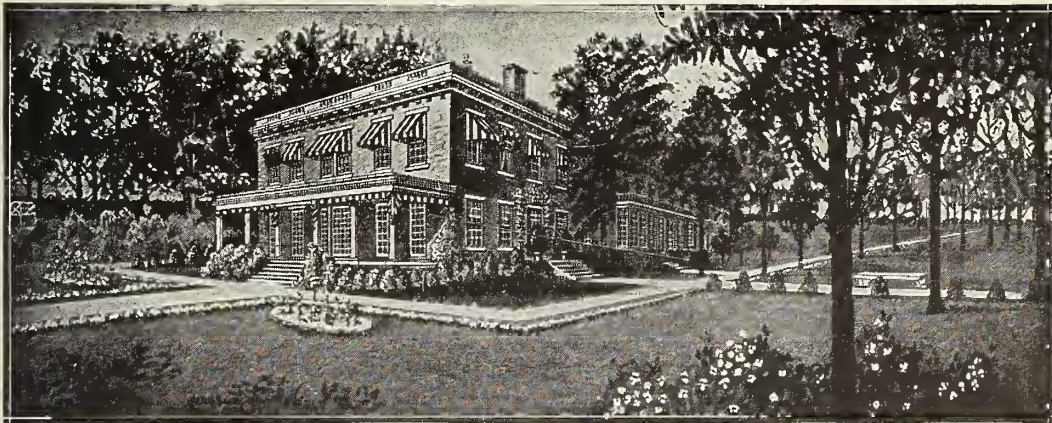
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MENTAL patients have every comfort that their home affords.

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COMMITTEE ON PUBLICITY

October 7, 1949

Present: James O. Ritchey, M.D., chairman; Homer G. Hamer, M.D.; Marlow W. Manion, M.D.; Frank B. Ramsey, M.D.; Ray E. Smith, executive secretary, and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of November 21—"Intestinal Flu."
Week of November 28—"Saving Eyesight."
Week of December 5—"Spreading Germs."

The radio health transcriptions, "The Public Comes First," was selected as the next series for use over WFBM, Indianapolis.

A request of the Woman's Auxiliary to the Grant County Medical Society for a speaker on mental health October 27, 1949, was referred to the 1949 chairman of the Committee on Mental Health with a request that he make recommendations.

The committee voted to purchase sufficient copies of the October 11 issue of *LOOK* magazine, if available, and send them to all licensed M.D.'s in the state.

Text of address prepared by the executive secretary for delivery before the Indiana University Dental Alumni Association at Bloomington on October 8, 1949, was approved.

October 21, 1949

Present: Marlow W. Manion, M.D., chairman; James O. Ritchey, M.D.; Homer G. Hamer, M.D.; and James A. Waggener, field secretary.

The following "Hints on Health" columns were approved:

Week of December 19—"Your Child's Hearing"
Week of December 26—"Pilonidal Cyst"

The radio health transcription, "Melody of Life," was selected as the next series for use over WFBM, Indianapolis, starting December 24.

The secretary reported that 117 speaking engagements have been filled through the state office during the past few months, and that speaking dates are now on file up through March 1950.

The secretary read a letter from the International Association of Accident and Health Underwriters in which they offered the facilities of their organization for assistance in the campaign against compulsory health insurance. They asked that physicians appear before insurance groups to discuss this subject, stating that the insurance industry was establishing a speakers' bureau that would be at the disposal of the profession.

COUNCILOR DISTRICT MEETING

THIRTEENTH DISTRICT

Dr. Kenneth L. Olson, South Bend radiologist, was elected councilor of the Thirteenth District to fill the unexpired term of Dr. Alfred Ellison of South Bend, president-elect of the Indiana State Medical Association, at the annual Thirteenth District Medical Society meeting held in South Bend on November 9. Doctor Olson's term will end December 31, 1950.

Dr. G. O. Larson of LaPorte was elected alternate councilor. District society officers elected were Dr. Louis E. How of Lakeville, president; Dr. D. D. Stiver of South Bend, vice-president, and Dr. O. E. Wilson of Elkhart, secretary-treasurer.

The 1950 meeting will be held in Michigan City on Wednesday, November 8, 1950.

Guests at the dinner included Dr. C. S. Black of Warren, president of the state medical association, and Ray E. Smith, executive secretary. The wives of physicians held a separate dinner, the guests of honor being Mrs. Truman E. Caylor of Bluffton, president of the state Woman's Auxiliary, and Mrs. Black.

The scientific program was as follows:

"Early Carcinoma of the Cervix: Clinical and Cytologic Features," by Drs. David A. Bickel and Carl S. Culbertson, both of South Bend.

"Proper Collection of Specimens for Laboratory Examinations," by Dr. Jene R. Bennett of South Bend.

"Cancer of the Lung: Its Early Diagnosis and Treatment," by Dr. Paul H. Holinger of Chicago.

"Bulbar Poliomyelitis—A Problem in Secretional Obstruction," by Dr. T. C. Galloway, Evanston, Illinois.

"Differential Diagnosis of Jaundice," by Dr. Edward A. Marshall of Cleveland.

"Medical Application of Nuclear Physics," by Professor Bernard Waldman, professor of Nuclear Physics, University of Notre Dame, South Bend.

Dr. Dan Urschel of Mentone, retiring district president, presided at the meeting.

LOCAL SOCIETY REPORTS

Boone County Medical Society members met at the Witham Memorial Hospital, in Lebanon, on September 13. This was a business meeting, and seventeen members were present.

At another meeting, on October 4, the members held a dinner meeting at the Ulen Country Club, in Lebanon. Fifty-eight members and guests were present. The guests included the wives of members, the nursing staff of Witham Memorial Hospital, and members of the Boone County Dental Society and their wives.

Clinton County Medical Society members held a meeting in Frankfort on October 4. Twenty members were present.

Fayette-Franklin County Medical Society members met at the country club in Connorsville on October 11. Eleven members were present, and heard Dr. Harry Landt, of Cincinnati, speak on "Electrocardiograph As An Aid In Heart Diseases."

Hendricks County Medical Society held a meeting at Merritt's, in Avon, on October 11. The guest speaker was Dr. C. Merle Bundy, of the Indiana State Board of Health, whose subject was "Better Community Tuberculosis Control." Eighteen members and guests were present.

Howard County Medical Society members held a meeting in Kokomo on October 7. The twenty-seven members present were shown in Eli Lilly and Company film on "Kidney Function in Disease."

Huntington County Medical Society held a meeting in Huntington on November 1. Dr. Maurice Glock, of Fort Wayne, spoke on "Diabetes." Nineteen members were present.

Jay County Medical Society members met at the Jay County Hospital, in Portland, on October 3. Dr. Lee Brown, of Hamilton, Ohio, spoke on "Common Orthopedic Problems of the Upper Extremity." Fourteen members were present.



The John N. Norton Memorial Infirmary announces the opening of a complete unit for the Treatment of Alcoholism

A new 125 bed addition financed by public subscription, supplemented by Federal and State grants, includes a 20 bed unit for treatment of alcoholism. A five-day period of treatment, which has proved to have the most permanent results, will be given under the direction of an internist especially prepared for this service. All other services of the hospital and consultation from any division of the

Medical Staff are available if required; particularly consultation from the newly organized Psychiatric Department, which is being operated on a post-graduate teaching basis in affiliation with the University of Louisville School of Medicine. An all inclusive fee will be charged for the standard five-day period. There are separated facilities for the care of women . . . For full information, write or telephone

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T. N. KENDE, M.D., Neuropsychiatrist, Medical Director
T. J. SMITH, M.D., Associate

LaPorte County Medical Society members met at the Peacock Fountain Inn, at Rolling Prairie, on October 20. Thirty-six members and guests were present. Mr. Ray E. Smith, executive secretary of the state association, spoke on "Pills and Politics."

Lawrence County Medical Society members met in Bedford, on October 5. The guest speaker was Dr. D. S. Megenhardt, of Indianapolis, whose subject was "Postoperative Care of Patients."

Noble County Medical Society members held a meeting in Kendallville on October 27. Dr. Frank W. Messer, of Kendallville, discussed regulations and potential regulations affecting the profession.

The society met again on November 4, at Albion, when twelve members were present. A resolution condemning socialized medicine was passed, and other business subjects were discussed.

Orange County Medical Society members held a meeting at West Baden Springs Hotel on November 1. The guest speaker was Dr. Selby Love, of Louisville, whose subject was "Gastroenteritis In Infants." Eight members were present.

St. Joseph County Medical Society members met at the Indiana Club, in South Bend, on November 1. Drs. J. E. McMeel and Ladislaus Faltin, both of South Bend, discussed "Newer Concepts of Cardiac Treatment."

Vanderburgh County Medical Society members met at Hotel McCurdy in Evansville on November 8. One hundred thirty-six members and guests were present, to hear Dr. Edgar A. Hines, Jr., of the Mayo Clinic, Rochester, Minnesota, speak on "Diagnosis and Treatment of Vascular Disease." Dr. George Willison, president, announced that approximately 80 percent of the members had paid the A.M.A. assessment. The society is making a special effort to reach 100 percent assessment collection by the end of the year.

WOMAN'S AUXILIARY

to the Indiana State Medical Association

President—Mrs. Truman Caylor, Bluffton.

President-elect—Mrs. D. E. Lybrook, Galveston.

Corresponding Secretary—Mrs. Harry Harvey, Fort Wayne.

Recording Secretary—Mrs. Bert Ellis, Indianapolis.

Treasurer—Mrs. Wendell Kelley, Anderson.

Press and Publicity—Mrs. Claude S. Black, Warren.

The Woman's Auxiliary in many counties in the state has been helping to organize a community council for the study of public health problems. This is a step in the right direction and will result in a greater understanding of the problems of general good health on the local level.

Outstanding speakers from the State Board of Health have addressed the groups and they have pointed out that people in every community in the state should be interested enough in their own health problems to do something about them. One of the important goals to be attained is the wide dissemination of health knowledge. Such knowledge is available through the State Board of Health. Application of known facts about a problem usually results in new approaches, and new approaches to the problem of public health promise new developments in the control of disease.

Organizations interested in this problem cut across the whole gamut of society. As a result, if personnel apply themselves to health problems, assistance can be brought to practically every sector of the community.

Knowledge of disease is the first step toward conquering it in a community.

Organizations moving within the orbit of these new community councils will have data on all types of disease. Application of this knowledge should prepare people for an invasion of most diseases, with results that epidemics could be avoided or largely controlled.

Books

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for more extensive review in the interests of our readers and as space permits. Books listed in this department are not available for lending. Any information concerning them will be supplied on request.

A TEXTBOOK OF NEUROPATHOLOGY—With Clinical, Anatomical Supplements. By Ben W. Lichtenstein, M.D., Associate Professor of Neurology, the University of Illinois College of Medicine. First Edition. 474 pages with 282 figures. W. B. Saunders Co., Philadelphia & London, 1949. Price \$9.50.

LIFE AMONG THE DOCTORS. By Paul de Kruif. 470 pages. Price \$4.75. Cloth. Harcourt, Brace & Company, New York, 1949.

CHILDREN IN CONFLICT. Twelve Years of Psychoanalytic Practice. By Madeleine L. Rambert. 214 pages. Price \$3.25. International Universities Press, Inc., New York, 1949.

A YEAR WITH OSLER. By Joseph H. Pratt, a member of the class of 1898. 209 pages, with 6 illustrations. Price \$4.00. The Johns Hopkins Press, Baltimore, 1949.

ATLAS OF OBSTETRIC TECHNIC. By Paul Titus, M.D., Obstetrician-Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; illustrations by E. M. Shackelford, formerly medical illustrator, John C. Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. Second Edition. 197 pages, with 203 illustrations. Price \$7.50. The C. V. Mosby Co., St. Louis, 1949.



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CLINICAL BIOCHEMISTRY. By Abraham Cantarow, M.D., Professor of Biochemistry, Jefferson Medical College; and Max Trumper, Ph.D., Commander, H(S), USNR., Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School National Naval Medical Center, Bethesda, Maryland. 4th Edition. 642 pages with 38 figures. Price \$8.00. W. B. Saunders Company, Philadelphia, 1949.

SHEARER'S MANUAL OF HUMAN DISSECTION— 2nd Edition. Edited by Charles E. Tobin, Ph.D., Associate Professor of Anatomy, University of Rochester School of Medicine and Dentistry. 286 pages with 79 illustrations. Price \$4.50. The Blakiston Company, Philadelphia, 1949.

MARIHUANA IN LATIN AMERICA—THE THREAT IT CONSTITUTES. By Pablo Osvaldo Wolff, M.D., member of Expert Committee on Habit Forming Drugs of the World Health Organization. Sponsored by the Washington Institute of Medicine. 56 pages. Price \$1.50. The Linacre Press, Inc., Washington, D. C., 1949.

FUNDAMENTALS OF OTOLARYNGOLOGY. A Textbook of Ear, Nose and Throat Diseases. By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School, and Associates. 443 pages with 184 figures. Price \$6.50. W. B. Saunders Company, Philadelphia, 1949.

OPERATIONS OF GENERAL SURGERY. By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. Second Edition. 890 pages with 1,700 step-by-step illustrations on 721 figures. Price \$13.50. W. B. Saunders Company, Philadelphia, 1949.

PSYCHOANALYTIC STUDY OF THE CHILD. Volume III/IV. Editorial Board: Phillis Greenacre, M.D., Heinz Hartmann, M.D., Edith B. Jackson, M.D., Ernst Kris, Ph.D., Lawrence S. Kubie, M.D., Bertram D. Lewin, M.D., Marian C. Putnam, M.D., Rudolph M. Loewenstein, M.D., Anna Freud, Willie Hoffer, M.D., and Edward Glover, M.D. 493 pages. Cloth. Price \$10.00. International Universities Press, Inc., New York, 1949.

WHAT SHOULD INDIANA PLAN IN RELATION TO RECOMMENDATIONS IN NURSING FOR THE FUTURE? Proceedings of the Workshop held at Indiana University January 5 to 7, 1949. 85 pages. Paper. Price \$2.50. Indiana University, Bloomington, Indiana.

A TEXTBOOK OF SURGERY by American Authors: Edited by Frederick Christopher, M.D., professor of Surgery, Northwestern University Medical School. 5th edition. 1,550 pages, with 1,465 illustrations on 742 figures. Price \$13.00. W. B. Saunders Company, Philadelphia, 1949.

AN ATLAS OF AMPUTATIONS. By Donald B. Slocum, M.D., Orthopedic Surgeon, Sacred Heart General Hospital, Eugene, Oregon. 562 pages, with 564 illustrations. Price \$26.00. The C. V. Mosby Company, St. Louis, 1949.

BOOKS REVIEWED

FUNDAMENTALS OF INTERNAL MEDICINE—3rd Edition. By Wallace M. Yater, M.D., Director, Yater Clinic, Washington, D. C. 1,451 pages with 315 illustrations. Cloth. Price \$12.00. Appleton-Century-Crofts, Inc., New York, 1949.

With a minimum of wordage, this text offers the latest accepted knowledge of the diagnosis and treatment of a wide range of diseases. The diagnostic charts are especially well done and should be of great help to the busy practitioner. Much useful information is provided as addenda to the text; for example, tables giving the normal and abnormal values for blood chemistry and also charts giving indications for the antibiotics and sulfonamides.

Kenneth G. Kohlstaedt, M.D.

THE YEARBOOK OF PSYCHOANALYSIS. By Sandor Lorand, M.D., New York, Managing Editor, Henry Elden Bunker, M.D., New York, Ernest Jones, M.D., London, Bertram D. Lewin, M.D., New York, C. P. Oberndorf, M.D., New York, Editorial Board. 356 pages. Cloth. Price \$7.50. International Universities Press, Inc., New York.

The papers in this yearbook are well chosen and should be of interest to the physician interested in psychoanalysis and the basic problems of psychodynamics. The average reader will find little of value in this book if he is searching for material that will be of practical value to him.

M. F. Greiber, M.D.,
Muncie.

ATLAS OF PERIPHERAL NERVE INJURIES. By William R. Lyons, Ph.D., Associate Professor of Anatomy, University of California Medical School; and Barnes Woodhall, M.D., Professor of Neurosurgery, Duke Medical School, Durham, N. C. 339 pages. Cloth. Price \$16.00. W. B. Saunders Co., Philadelphia and London, 1949.

This atlas supplies a summary of the present knowledge of peripheral nerve injuries with emphasis on the gross and microscopic tissue responses. A series of excellent photographs and photomicrographs amply demonstrate each point of discussion, and case histories taken from Army Neurosurgical Centers add further emphasis.

There is no attempt to teach surgical technique, other than a general discussion of methods used, that would be useful only to those already accomplished in the handling of peripheral nerve injury.

The atlas should be of interest to those learning neurosurgery and to pathologists and anatomists interested in this special field.

James A. McClintock, M.D.

THE PRACTICE OF REFRACTION. By Sir Stewart Duke-Elder, M.D. 317 pages, 216 illustrations. Cloth. Price \$6.25. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri.

The value of the book to beginners is attested by its continued popularity, the fourth edition having had three printings. In the fifth edition the practice of refraction itself is essentially the same. Aniseikonia and accommodation are treated at greater length. A half page has been added for streak retinoscopy. Muscle imbalance and convergence are well treated and the author has briefly discussed the newer concepts of the etiology of myopia. However, in the fourth volume of his textbook of ophthalmology, also just published, he treats this subject in much more detail.

R.F.C.

HOW TO BECOME A DOCTOR. By George R. Moon, A.B., M.A., Examiner and Recorder, University of Illinois Colleges of Medicine, Dentistry, and Pharmacy. 131 pp. Cloth. Price \$2.00. The Blakiston Co., Philadelphia.

This book is Mr. Moon's attempt to present adequate information for prospective medical students, so many of whom have been misinformed. It contains a summary of the admission requirements of the leading medical colleges, and how to apply for admission, as well as the methods of the admission committees. A chapter is devoted to a discussion of women and medicine. He then goes into the medical curriculum and the students' problems and chances for survival or failure. Here he points out the common misbelief that students flunk en masse from medical school, whereas the fact is that 90 to 95 percent "ultimately earn the M.D. degree."

Brief chapters on Dentistry, Pharmacy, and other allied fields are included. They are brief, due to the similarity of procedure of application, interview, and admission.

"How to Become a Doctor" is a very enlightening book which bares many problems frequently overlooked, the solution of which helps toward admission and success.

Two indexes are included—one of schools and colleges, and one of general information. Both are very complete.

BLAKISTON'S NEW GOULD MEDICAL DICTIONARY.

First Edition. Edited by Harold Wellington Jones, M.D., Colonel, U. S. Army; Normand L. Hoerr, M.D., Professor of Anatomy, School of Medicine, Western Reserve University; Arthur Osol, Ph.D., Professor of Chemistry, Director of Chemistry Departments, Philadelphia College of Pharmacy and Science. 1294 pages with 252 illustrations, 129 in color. Textbook edition \$8.50; thin paper edition \$10.75; deluxe edition \$13.50. The Blakiston Company, Philadelphia, 1949.

Edited by three men with the assistance of an editorial board and over 100 contributors, this is the first new medical dictionary in 38 years.

More than 300 modern texts as well as journals, yearbooks and standard indexes in all basic fields were critically examined for new words and changes of usage; all definitions were written by specialists actively at work in the various fields and each entry was carefully checked and arranged according to modern lexicographic standards demanding brevity, clarity and accuracy. Hundreds of new words are included that can be found in no other medical dictionary; each new word was examined and analyzed by many experts before being accepted.

This is the first medical dictionary to combine a system of modern phonetic respelling with syllabification, to give alternate pronunciations, and to cross-reference from definitions to illustrations. Special tables of arteries, enzymes, vitamins, monstrosities, etc., are grouped in a special section for easy reference. Bound into the center of the book is an atlas with 252 illustrations, 129 in color.

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One Hundred Years of Indiana Medicine 1849-1949

*Published in connection with the
Centennial of the*

INDIANA STATE MEDICAL ASSOCIATION

DOROTHY RITTER RUSSO, *Editor-in-Chief*

Prepared under the direction

of

CHARLES N. COMBS, M.D.

and

EDGAR F. KISER, M.D.

First Installment

1949

FOREWORD

CICERO gave his appraisal of history in three dimensions: the truthful witness of the times—the teacher of life—and the messenger of antiquity; in other words, the description of events from an unbiased perspective, the observations of experience from which much may be learned, and lastly, the record of the past.

History of that time was probably in large proportion a record of political and governmental change. Science was young as compared to modern status and progress.

In the years that have passed since the observations of Cicero, science has progressed more rapidly than political and sociological changes. In fact, without the light of scientific discoveries and progress, the culture of today, in a broad sense, would not have been possible. Science is continuously in process of change. The speed with which that change takes place is irregular and the direction may be rapidly forward in progress and expansion, or slowly engaged in revision and change based upon new discoveries.

Medicine, despite its scientific background, is a service to mankind. The progress of its development is therefore modified by the conditions under which the human recipients of that service live. Educational and sociological factors may promote or delay the application of scientific knowledge to the health problems of varying areas or groups of individuals.

The history of one hundred years of medicine in Indiana is in substance the story of the people, their lives, and the efforts of physicians and others to maintain good health. Indiana established medical schools at an early date in its history and has continued medical instruction without interruption. Indiana has good hospitals, qualified nurses and trained medical personnel. The medical profession of Indiana has not only given good service but has made noteworthy contributions to medical knowledge.

It is hoped that this review of the advancement of medicine in Indiana and evaluation of the benefits to the people may serve as an inspiration to the younger generations, now in medicine, to devote a full measure of scientific effort and kindness to the objectives of good health and happiness.

The people of this state are greatly indebted to the Indiana State Medical Association for a high quality of medical service. I am honored in having had the opportunity to serve for a time as its president. Therefore, I know how much time and effort is devoted to study, planning and leadership in medical matters by the members of this medical organization. Without this cooperative effort, present accomplishments would not have been possible.

Indiana has not been inclined to wild political experiments and it is hoped that the same sound reasoning will guide the state through the present turmoil of political and sociological ideologies.

As president of the American Medical Association, it is with great pleasure that I extend congratulations to a constituent society, the Indiana State Medical Association, on the completion of one hundred years of outstanding contribution to medical progress.

ROSCOE LLOYD SENSENICH, M.D.
South Bend, Indiana

May 12, 1949

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ONE HUNDRED YEARS OF INDIANA MEDICINE

I

PIONEER MEDICINE IN INDIANA

DOROTHY RITTER RUSSO*

INDIANA'S settlement was a gradual process. French explorers and fur traders came from Canada during the eighteenth century. They established forts at the present Fort Wayne, also at Ouiatenon (near Lafayette), and at Vincennes. It was in Vincennes, in the year 1731, that the nucleus of the first Indiana town was contained. From the East there came, down the Ohio River, the English and those who could call themselves "Americans" because they had been born in this country. Clarksville was settled in 1784. Americans took over Fort Wayne in 1794 and a town grew up there. Most of the early settlements were along the Ohio and from them the settlers gradually spread to other parts of the state. Streams were used for traffic and traces became roads. Hordes of toiling immigrants, however awed by the great forests, drove through them and hewed them into timber.

Our pioneer medical history cannot be separated from the pioneer life that characterized the period up to 1849.

A shifting group of nomads preceded and accompanied homebuilders: restless persons, scouts and wanderers, led by curiosity to seek new lands, courting dangerous adventure. It can be assumed that in their passage, largely unrecorded, these people experienced illness and injury; that they received care through the missions established by the French priests. Some scouts had a rudimentary knowledge of healing methods, scarcely deserving the designation, medical practice.

The doctor as we know him now, a man willing to stay in a community and nurture his practice by patient daily labor, came with the group that we call settlers. These were the people who built homes, established schools and churches and laws of government. They gathered together for protection and pleasure. Medical societies were a natural outgrowth in the territory that became a state in 1816.

Army doctors served the western posts at Vincennes¹ and Fort Wayne in the eighteenth century. They differed in qualifications as well as in personality, but the fact that they had received training in general practice and surgery, conforming to certain standards, gave them the status of pro-

fessional men. Some, resigning from the army, stayed on to become part of the settled communities.

The Indian medicine man aided the white men by pointing experienced fingers toward native medicinal plants. We have been led to visualize him as a witch-man, shouting or mumbling incantations, throwing his body into strange contortions to frighten away devils of disease. While he catered to the superstitions of his tribe, there are indications in historical writings that he showed toward civilized people a measure of dignity and skill which brought many of his kind to friendship with the settlers. Some of the French families in and near Vincennes valued the services of Indians as healers. Some sixty of their drugs are found today in the *materia medica* and among the medicaments compounded by standard pharmaceutical houses.

All the histories of our state pay tribute to the mother in the home for the medical aid she furnished when physicians were not obtainable.² Wives, widows and grandmothers have been described as skilled female doctors, although their only education came through meeting emergency needs in a sparsely populated community that depended largely upon home remedies and common sense. A woman who could not help herself, her family and her neighbors, had no place in the hard life of the pioneer and did not survive long.

The medical men who came from the East in the early nineteenth century have been pictured as colorful figures, eccentric, always ready for a fight, more individualistic than doctors of today. Their way of living as pioneers was rough and their battle to save lives heroic. Epidemics spread quickly, with smallpox a frequent dread visitor even before its disastrous outbreak in Vincennes in 1793.

Autumnal fevers made life miserable for the early settlers. These fevers, described at the best as "depleting," as they manifested themselves in various ways, were called by many names: bilious, intermittent, congestive, miasmatic, malarial, marsh, malignant chill fever, ague, fever and ague, or, more simply, "the Fever."³

Dr. S. G. Mitchell graphically described autumnal fever in Indianapolis: "The settlement of the

* Indianapolis, Indiana Historical Society, research writer, compiler of bibliographies of Indiana authors.

¹ The first physician recorded in Vincennes, probably the first within the present limits of the state of Indiana, was Charles Louis Olivier-Santier, a surgeon from Quebec, whose name appears in 1761 in the register of St. Francis Xavier Church.

² British bookdealers today make an interesting category in their catalogues of technical books that is applicable here: "Mothercraft and Medicine."

³ Dr. Daniel Drake's list in the *Second Series* of his *Diseases of the Interior Valley* (1854), p. 2.

town was commenced in 1820, when the plain was heavily timbered with various kinds of trees. In the spring of 1821 these were extensively cut down, and immigrants crowded upon the spot, until by midsummer, they numbered about six hundred. They were miserably lodged in open cabins, shanties, and even tents, and subsisted largely on fish and game, with little salt. July and August were unusually hot and wet. Everything molded. The luxuriant foliage of the fallen trees and trodden-down annual plants underwent a rapid decomposition. Exhalations offensive to the smell arose. Many domestic animals died, and in the latter half of July, intermittent and remittent fevers appeared. They commenced near the rivers, and extended eastwardly through the new village, assuming a malignant character. Before the epidemic closed in October, nearly every person had been more or less indisposed, and seventy-two, or about an eighth of the population, had died. Many of the most malignant or algid cases commenced as simple intermittents."⁴

The above-described conditions were general in all settled regions except the prairie lands of the north-east, causing a regular season of sickness, from the first of August to the first of October. The early residents accepted it as a period of enforced cessation from labor, a test of endurance.

A foe of the frontiersmen was "milk sickness." This disease, from which the mother of Abraham Lincoln and many less famous pioneers in Indiana died, was caused by cattle and other animals eating white snake root (*Eupatorium*).

Erysipelas, a type called "Black Tongue," was frequently epidemic, as were dysentery, whooping cough and scarlet fever. Typhoid fever made its appearance, too, but neither typhoid nor typhus were common in our state. Asiatic cholera struck Indiana in the winter of 1848-1849. The suddenness of its onslaught brought terror with it and the high fatality called for imperative measures in the way of preventive medicine. It was probably the emergency that helped secure a hearing for those who recommended rules of health and cleanliness, ways of living that later were to lessen other evils.

How did the early doctor meet these situations professionally? The first thing to remember is that he had to travel by riding horseback, his horse thus becoming his most valued assistant. Saddle-bags ("pill-bags") were needed to carry all his stock in trade. His sparse equipment has been described as: "Mortar and pestle, a set of balances, some home-made splints and bandages, a few drugs, possibly a small assortment of instruments [lancets], perhaps a pewter bedpan, a few simple syringes, and pewter or crockery hot-water bottles."⁵ By the late 1830's most of the doctors also carried a stethoscope, a simple cone-

shaped tube, plus a set of tooth forceps and a few obstetrical instruments.

Fees charged are known from bills that have been preserved and from records of the early medical societies. For instance, at the opening of the century a certain Vincennes physician was receiving \$2.00 for a visit in town; did venesection for 50 cents; dispensed four pectoral powders for \$1.00, two doses of jalap for half this amount. In 1805 another doctor was being paid 25 cents for extracting teeth, \$5.00 for accouchement; dispensed a dose of calomel and tartar emetic for 50 cents, twenty mercurial pills for \$1.50; charged 62½ cents for an ounce of paregoric "and vial." In the 1820's the cost of drugs had fallen and the usual fee for a town visit dropped to \$1.00. In 1848 for venesection or blisters a doctor received 50 cents; for accouchements he was paid \$5.00 to \$10.00; gave vaccinations for 50 cents to \$1.00; made town visits for \$1.00 but asked double for night calls.

One wonders how the physician of that period, more or less isolated by the difficulties of transportation, could have procured enough of expensive, European-manufactured drugs to meet the needs of the annual "sick season" or the crisis of an epidemic. For the first he might be prepared by planning on the basis of past experience; for the second he must use heroic means. Often he was forced to turn to plants in the native forests and it did then sometimes happen that medical aid approached or became, in unscrupulous hands, what we call quackery.

In their honest efforts to heal sick people, doctors of pioneer days used methods which seem astounding to the modern physician, but were then regarded as efficacious and "modern." One account describes the prevailing practice thus: "In the early settlement, the 'regulars' in the treatment of fever relied mainly upon one remedy—calomel. It was indeed extraordinary upon the part of any physician to treat any form of disease without the generous use of large doses of calomel. Not to salivate a patient seemed to be regarded as almost allowing him or her to go to the grave without a saving effort. A patient 'sick of a fever' must also be freely bled before an internal remedy was administered. The lancet held sway alongside of calomel. If, in raising a log cabin, a man was thrown from his 'corner' and badly bruised, the practice was to bleed him copiously on the spot as the first step toward his recovery."⁷

Jalap was a cathartic administered in large dosage. Emetics were in high favor, among them

⁴ A listing quoted from *The Midwest Pioneer: His Ills, Cures and Doctors*, by Madge E. Pickard and R. Carlyle Buley (1945).

⁵ These fees, being typical, are all quoted from Dr. Patton's report in *A Medical History of the State of Indiana*, by G. W. H. Kemper (1911), pp. 11-12.

⁷ *A Medical History of the State of Indiana*, by G. W. H. Kemper (1911), p. 111.

⁴ Daniel Drake, *Diseases of the Interior Valley (First Series, 1850)*, p. 311.

nitrous ether, sometimes added to a nauseating saline draught, with opium used afterwards as a soothing agent. Blisters were employed with greater frequency than cupping or leeching, and Dr. Drake tells us that "almost every patient had a blistered surface on some part of his body throughout the whole period of his confinement." After a week or so of such preparation, "the bark and other tonics were administered." Quinine remained more or less on trial between 1839 and 1844, and was costly (\$30.00 an ounce in its early introduction), but came into general acceptance when it was proved to cut down the death toll. All too often the chills, the raging fever and intense, insatiable thirst of the ague and its close relatives were stopped only by the death of the patient or the arrival of cold weather. The use of quinine undoubtedly changed that picture somewhat but preventives were badly needed.

A source of relief to the pioneer was the drainage of swamps which brought about the destruction of the mosquitoes that, unsuspected for so long, were the carriers of malaria. The disappearance of cholera and typhoid fever came from the raising of sanitary standards generally. It has been suggested that the reason why the "wasting diseases" carried off so many, while degenerative diseases of heart, kidney and liver were apparently so little encountered, is that people did not live long enough to develop them. Infections that later plagued our city inhabitants were non-existent in the isolated living of pioneer days, and injuries healed quickly. Habits of indulgence in eating and drinking were a greater cause of trouble. Dr. Drake as a contemporary writer said: "Such an excess is the natural effect of living in a country whose greatest natural characteristic is productiveness of sustenance; and until the abundance of the latter in proportion to the population shall diminish, the practice will continue." He intimated that more animal food compared with the vegetable was consumed by the inhabitants of the Interior Valley of America than by any equal number of people in the whole world, and claimed that the culinary arts were little understood by the great majority "who find in quantity and variety a substitute for qualities which depend on skillful cookery." The fact that houses were inadequately ventilated and unevenly heated was a cause of trouble, one particularly dangerous to children and young women predisposed to consumption. Deaths among babies were so common that mothers breathed a sigh of relief when they brought them through their second summer.

The very nature of agricultural labor, with its exposure to the elements and its tax on joints and muscles contributed to break down the health and strength of some pioneers, although it gave firmness and endurance to others. Those who worked on flat boats and keel boats, floating them down the Ohio River, had a choice of laboriously pro-

pulling themselves back against the current, or of making the return journey, sometimes a thousand miles, by foot or horseback. The hardships of such a trip brought fevers, rheumatism, and pulmonary diseases to some of these watermen. With the introduction of steamboats the trip back was made physically easy but hazardous to those inclined to yield to dissipation, (so we are told).

The newly organized state of Indiana in 1816 passed laws regulating the practice of physic and surgery, and calling for the organization of district medical societies. This shows that there was already recognition of the need to protect its people from malpractice. Untrained persons were undertaking to cure all by secret nostrums. A national pharmacopoeia was being talked of, and the call to help in its compilation was one of the chief considerations of the First District Medical Society organized in Vincennes in June, 1817, and the Second District Society in Jeffersonville, organized July 1817. A third society met in Madison in August 1817. Powers were given to censors and officers of the societies to grant licenses to qualified physicians, and to expel physicians for immoral or disorderly conduct, or for using secret nostrums and refusing to divulge them to other members. The efforts of these early medical societies to guard standards and raise them resulted in much good. Foremost in their code of ethics was a way of practice well described in the 1834 report of the Vincennes Medical Society: "It is the duty of every medical practitioner to treat his patients with steadiness, tenderness and humanity and to make due allowance for that mental weakness which usually accompanies bodily disease."

Little of steadiness is found in the practices of the "empiricals," the later "botanics" and the promoters of various "isms" that flourished for a while and waned through an insufficient leavening of common sense and feeble body of truth. Their advertisements in periodicals lured the sick with bright promises. Patent medicines were presented by print and word of mouth as cure-alls, showmanship selling nostrums to young and old.

Medical books before 1830 were not common. The "family doctor book" was much in evidence, being the only source of medical information in isolated homes where a physician could not be reached for every need and the housewife took on the service of both doctor and nurse. A glance at the medical libraries of our early practicing physicians would show the sparseness of the written guides in their possession. They were fortunate if they owned such standard texts as Bell's *Surgery*, Cullen's *Practice of Medicine*, and Hamilton's *Obstetrics*. The more scholarly physician would be certain to have Sydenham's works in some English edition, or, perhaps, in the Latin. Books shipped from abroad were expensive, and book shops were few west of Philadelphia. The insecurity of the pioneer doctor's living did not

inspire him to collect material things beyond the needs of his body and of his traveling adjunct, his horse. His memory and his daily experiences took the place of reference books.

In the 1830's medical literature was more abundant, for by that time American writers had arisen to make their contributions, mostly by adapting foreign texts to the needs of this country and having them published in the United States. There were some original writings by teachers in our few medical schools, but recognized works by European men of note were more generally used. Some of the "classics" went through many editions, with notes added by numerous editors. The "botanical school," so called, was producing its guides in Ohio, reaching advocates in Indiana.

The first medical book known to have been printed in Indiana appeared in 1832 and came to the light of public recognition this year. It is a pamphlet of 72 pages plus index, untrimmed, issued in plain tan wrappers:⁸ *The Sick Man's Companion, or The Preserver of Health, treating diseases common to this country, according to the most successful practice. To which is added a short and comprehensive description of the medi-*

⁸ The copy in the William Henry Smith Memorial Library, Indiana Historical Society, unfortunately has some pages wholly or in part missing.

cines used in the practice, and their doses, by Dr. C. Vanhook of Vincennes; Vincennes, Indiana: E. Stout Printer, Office of the "Western Sun"; 1832. The author discusses "intermittent fevers" and "remitting fever," inflammations, burns and toothache; has a section on materia medica and botany. This antedates S. H. Selman's *Indian Guide to Health*, published in Columbus in 1836, the earliest known cloth-bound medical book published in Indiana. Of the other twenty-four known Indiana medical imprints before 1850, three were "Indian guides," one a treatise on domestic medicine, two were editions of Dr. Buell Eastman's treatise on midwifery (1845), and the rest had to do with epidemics, medical societies, and medical schools.

The medical men of this early day added service in community enterprises to professional duties, earning high regard as good citizens. Special honor belongs to the doctor who was called upon every day to travel great distances without the aid of defined roads, with his saddle-bags laden with roots, herbs and barks, with few and inadequate instruments, without anesthetics for aid in the performance of both major and minor operations. His work was done in homes under conditions that called for heroism on the part of both physician and patient. The results of his labors are shown in the unfolding of our history.

II

HISTORY OF THE INDIANA STATE MEDICAL ASSOCIATION

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THIS history does not presume to be of epic proportions nor yet is it the "simple annals of the poor," but it does attempt to portray a creditable narrative of the development, organization and progress of medicine in a typical and important state in the great mid-west.

The author has read the detailed stenographic reports of every annual session since 1849 and finds therein a protocol from which to relate events, to recreate the mise-en-scene and to comment on trends and characteristics. It would require an abler pen to delineate the prophetic vision, the indomitable courage and the fine motivation that underlies and buttresses the mature and virile association as it now stands.

Some time ago, Dr. Olin West, then secretary of the American Medical Association, supplied a list of the different state medical societies with the dates of their inception. On that list Indiana ranked number seventeen but the first ten of these were eastern sea-board states where the earliest settlements existed and most of them were organized in the 18th century. Three others were

southern states whose associations ceased to exist during the Civil War and were reorganized later. Only Tennessee (1830), Ohio (1846) and Pennsylvania (1848) had a continuous record antedating Indiana.

Dr. H. M. Smith of Vincennes in a paper about "Early Indiana Medical History" (Transactions 1906) writes, "If I mistake not, the State Medical Society organized in 1849 is supposed to have been the first state organization, which is in error. To controvert that opinion I herewith quote from the Transactions of the Vincennes Medical District Society the following: 'This Society proceeded to elect delegates of the State Medical Society (in 1827).' 'Resolved that this Society do allow the sum of ten dollars to the delegates annually to the State Medical Society.' And in 1830 a like sum was appropriated. These records establish the fact that a State Medical Society existed as early as June 5, 1827, and perhaps earlier and the one organized in 1849 was the second State Medical Society."

However, our story concerns only the present association which has a proven uninterrupted existence since 1849 as attested by the bound trans-

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actions issued each year. To relate the early history why should one paraphrase the meager data extant, when there exists in his own words an account written by an eye witness and a participant in these events? Dr. W. H. Wishard recounted the early activities in a paper he read before this Association in 1899 celebrating its semi-centennial. The entire address is printed in the Transactions of 1899 and was reprinted in his biography, "A Doctor of the Old School," written by his daughter, Miss Elizabeth Wishard.

Quoting in part: "There were a few medical societies in different parts of the state, and many of the leading physicians had long desired a state organization. Indianapolis had a local society composed of the leading physicians of the place. They sent out a call in May to their professional friends to meet June 6, 1849, at 10 o'clock a.m., in this city. Pursuant to that call the physicians met in Wesley Chapel at the hour named. Dr. John H. Sanders was called to preside as temporary chairman. The chair appointed Dr. John S. Bobbs temporary secretary. Then they proceeded to make out the roll of all the physicians; twenty-eight answered to their names. After roll call Doctor Mothershead moved that the president appoint a committee to recommend officers. The committee named the following: for president, Dr. Livingston Dunlap; vice presidents, Dr. N. Johnson, Dr. T. Ryan, Dr. J. W. Florer and Dr. C. Wallace; secretaries, Dr. John S. Bobbs and Dr. A. M. Hunt. After the appointment of a committee to prepare the business of the convention the society adjourned to meet at 3 o'clock p.m. The meeting reassembled in the afternoon, with the president in the chair. A committee of nine was appointed to formulate the constitution and by-laws. Another committee was appointed to report on the expediency of establishing a medical journal. A committee was also appointed to memorialize the legislature on the subject of homicidal insanity. A committee was appointed to overture the legislature to prepare suitable laws for registration of marriages, births and deaths. The convention accepted invitations to visit the various benevolent institutions of the city. The meeting adjourned to meet at 8 o'clock the next morning, June 7. Doctor Dunlap was in the chair and the minutes of the previous day were read and approved. Doctor Bobbs, on behalf of the committee to formulate a constitution and by-laws of the state society, made a report, which was accepted, and the constitution and by-laws were taken up and discussed section by section, amended and passed. The afternoon meeting opened at 1:30 o'clock, with the president in the chair. Doctor Parry made a lengthy report on the duties of a physician. It elicited considerable discussion, and was unanimously adopted. Doctor Curran reported on the subject of establishing a medical journal, and recommended the same. His report was lengthy, and ordered to be spread on the minutes. The Society adjourned to meet again

at 6 p.m. for the purpose of visiting the hospital for the insane. In compliance with the resolution offered by Doctor Mears, the names of fifty-seven physicians residing in different parts of the state were voted upon as suitable persons to become members and were elected. A committee of five was appointed to nominate officers for the ensuing years.

"The committee reported the following names: for president, Doctor Cornett of Versailles; vice presidents, Drs. A. Clapp, N. Johnson, L. Dunlap and Farquhar; secretary, Dr. John S. Bobbs; assistant secretary, Dr. A. M. Hunt; corresponding secretary, Dr. L. Bullard; treasurer, Dr. Mothershead; librarian, Dr. Jameson. A standing committee of five on admission to membership was appointed, also an executive committee, a finance committee and a committee on publication and medical ethics. Delegates to the American Medical Association were elected. Doctor Florer, on behalf of the members from a distance, tendered thanks to the physicians of this city for the courtesies and attention shown them during their visit. A resolution of thanks to the officers for the efficient manner in which they discharged their duties was passed. Pending a motion to adjourn the president, Doctor Dunlap, made a brief address, thanking the society for the harmony that had characterized the meeting and foreshadowed the advantages and profit such an organization would be to the profession at large. The meeting then adjourned to Washington Hall, where it resumed its deliberations around a sumptuously spread table which was prepared by the physicians of the city. At 10 o'clock p.m. the society adjourned to meet the following year, 1850.

"Thus ended the first meeting of the Indiana State Medical Society. Two days were spent in hard work, and although no papers were read on medical subjects, there was laid deep and wide the foundation on which the successors of that meeting have so wisely built, and today we are reaping a rich harvest from the seed that was sown fifty years ago. The following is the roll of the twenty-eight charter members who were present; four only can answer today.

"Physicians present at the organization, June 6, 1849:

John H. Sanders, Indianapolis
 William C. Thompson, Indianapolis
 Livingston Dunlap, Indianapolis
 John L. Mothershead, Indianapolis
 R. J. Patterson, Indianapolis
 A. D. Gall, Indianapolis
 C. S. Ramsay, Indianapolis
 George W. Mears, Indianapolis
 R. Curran, Indianapolis
 T. Bullard, Indianapolis
 Charles Parry, Indianapolis
 A. M. Hunt, Indianapolis
 John S. Bobbs, Indianapolis
 P. H. Jameson, Indianapolis
 J. M. Gaston, Indianapolis
 D. Funkhouser, Indianapolis

J. Nutt, Marion County
 H. N. Johnson, Broad Ripple
 Alexandra J. Mullin, Napoleon
 H. N. Johnson, Cambridge City
 Vierling Kersey, Milton, Wayne County, Indiana
 T. W. Florer, Alamo, Montgomery County, Indiana
 John Hunt, Madison County, Indiana
 T. Ryan, Anderson, Indiana
 Charles Wallace, Belleville, Hendricks County
 David Hutchinson, Mooresville, Morgan County
 W. R. Smith, Cumberland
 William H. Wishard, Greenwood, Johnson County

"But there were 56 more members taken in the next day, so the total attendance was 84.

"The second annual meeting of the society met in the lecture room of the Baptist Church, Wednesday, May 15, 1850, presided over by Doctor Cornett, the president, that old Roman and pioneer of the profession, whose life was a benediction to all. The executive committee requested that the president be asked to read his paper on the 'Rise, Progress, Present State and Future Prospects of the Medical Science,' at early candle light the first night. Yes, it was candle light, for those were primitive days. The address was able and lengthy. If it could be read today you would say it was prophetic, and foreshadowed what has come to pass. The president's address and a paper from Doctor Bobbs were the only written addresses at that meeting. After the discussion of the usual business the society adjourned.

"The third annual meeting occurred in the lecture room of the Second Presbyterian Church of this city, May 21, 1851, Dr. A. Clapp, president. At this meeting a number of papers of merit were read. The by-laws of the society were so amended as to enable the society to meet wherever a majority of the members decided. After discussing the regular business of the society the meeting adjourned to convene at New Albany the following year.

"The State Society met in the Second Presbyterian Church of New Albany, May 19, 1852. Dr. George W. Mears was president. There were thirty-nine members in attendance. A number of papers were read on medical subjects, and all were worthy of a larger hearing. After discussing the usual business the society adjourned to meet at Lafayette in 1853.

"The Society met in the courthouse at Lafayette, Wednesday, May 18, 1853, the president, Dr. J. H. Brower, presiding. Fifty-eight members were present. At this meeting of the society more papers were read on medical and surgical subjects than at any two former meetings, covering one hundred and fifty-four pages of the Transactions. The paper of Doctor Harding, chairman of the committee on practice, was on the 'Practice of Medicine, or the Treatment of Diseases in Eastern Indiana.' The paper was exhaustive, and covered thirty-two pages of the Transactions. It is well worth reading today. Doctor Bobbs reported on 'Surgery,' and Doctor Sutton on 'Milk Sickness.' There were

other valuable papers also. This meeting was one of unusual interest, and adjourned to meet at Evansville, May 17, 1854.

"The meeting at Evansville was held in the hall of the Medical College, Doctor Deming presiding. The roll call indicated forty-one in attendance. The papers read at this meeting were up to the usual standard. Dr. Wm. W. Mayo read a paper entitled 'The Pathological Indications of the Urine,' and was the first paper of the kind read before the society. Doctor Deming, the president, known as the 'old man eloquent,' gave an address on 'The Moral Dignity of the Profession,' which should be read by every physician.

"The next annual meeting of the society was held in the lecture room of the Second Presbyterian Church, Indianapolis, May 18, 1855. The president was Dr. M. J. Bray, of Evansville. Fifty-three members were registered. A paper was read by Doctor Brower on the 'Profession of Medicine.' Reports on 'Obstetrics and Puerperal Fever' were given by Doctors Graham, Murphy and Florer.

"The society met May 20, 1856, in Indianapolis, in the Second Presbyterian Church, where it met the previous year, eighty-six being in attendance, the largest number that had attended so far. There were fifteen papers read on different subjects pertaining to medicine and surgery, all of which were profitable to the profession of the state in those days.

"The eighth annual meeting was held in Indianapolis, May 19, 1857, in Washington Hall. Dr. Daniel Meeker, of LaPorte, was president. Forty-six members answered to their names and twenty-four new members were added, making a total attendance of seventy. Ten papers were presented.

"Having hastily reviewed the first eight annual meetings of the society, shall we not reflect, compare and see what has been accomplished? At the organization there were but twenty-eight delegates. After the meeting at different points over the state the membership increased to three hundred and fifty-three, while the average attendance at the annual meetings was only about forty-five. The question arises, why this discrepancy between the membership and attendance? We must remember the railroads were few in those days, and the delegates generally had to go by their own conveyances. Physicians were ready to join when the societies convened near their homes and attendance was thus made easy. With the exception of a few faithful ones, many were never heard from at subsequent meetings. After 1857 the society met at various cities throughout the state, and added to its membership from the profession in the vicinity where the meetings were held. As facilities for traveling increased the attendance was enlarged. However, it varied according to location, which also influenced in some degree the standard of the papers.

"The constitution was changed, whereby the society became a delegate body. I regret that I

am unable to give the exact date of this change. Though opposed by a respectable minority, it was a wise move, and freed the society of which might be called 'tramp' delegates and stimulated the organization of county societies, as only those who are members of the local societies are recognized as delegates to the state meetings.

"During the Civil War the attendance of the meetings was greatly reduced. Many of the best physicians were in the army, and others were too much occupied to attend."

Supplementing this are the impressions recorded by Dr. G. W. H. Kemper in his "Medical History of Indiana," valuable and authentic because Dr. Kemper knew and talked with many of the founders.

He says, concerning the first meeting, that it was "styled 'Convention' and not 'Society.' In fact it was not regarded by those present as a regular meeting of the society, but rather an assembly for the organization of a state society. It was the Declaration of Independence for medical societies in Indiana."

"At this preliminary meeting a number of practical questions were discussed and acted upon. One was the expediency of establishing a medical journal, and Drs. George W. Mears, Vierling Kearsey and Robert Curran were appointed a committee to report some definite action, but it was many years before a journal was created.

"On motion of Dr. John H. Sanders, it was 'Resolved, That a Committee of five be appointed to memorialize the Legislature, asking them to provide by law for a registration of marriages, births and deaths.' The good seed sown by those early pioneer physicians has borne fruit and they deserve praise for their forethought.

"Also at this meeting they grappled with problems that, for the sake of science, we all regret they left undetermined: Resolved, That a Committee be appointed by the president to collect, in a systemized form, facts on the duration of pregnancy, and the causes which influence sex."

The first constitution adopted contained the basic principles which are perennial in so far as they concerned our objectives, such as fostering the development of scientific medicine, protecting the public health and safeguarding our own interest in maintaining an organized medical profession. It was sketchy compared to the one we now have and the organization was loosely constructed and lacked the rigid pattern necessary for endurance. For instance, on a two-thirds vote a physician could join directly even though he was not a member of the local society. The initiation fee was \$2.00.

Four permanent committees were set up: one on Ethics, to prosecute violators of the Code, and that was highly important then as there were no legal safeguards; one on Finance to see that the expenses did not exceed the income; one on Pub-

lication which provided us with the Transactions so that our records are preserved; and one called the Executive Committee to transact all business affairs. By 1859 there were committees on every branch of medicine and even the twigs of particular diseases with annual reports on the same.

1861. Instead of any member attending, being allowed to vote, the county societies appointed delegates for that purpose. There was proposed a College of Guardians of Health to provide a list of competent doctors to be proclaimed to the public as such, but nothing materialized. A committee was appointed to investigate the microscope and later a paper was read describing it and recommending its use.

1862. Many state medical societies and even the American Medical Association missed one or more meetings during the Civil War, but Indiana did not fail to keep going. However, the usual May meeting was postponed until November and the attendance was slight. The membership was then 300 and the annual expense was \$93.00.

1863. The Association met for two days only. An important paper was the one on "Camp Diarrhea" and also the report of the Committee on Military Surgery.

1864. Here occurs the first publication of a list of county society members. Adopted, was a resolution that doctors should prepare and prescribe their own medicine. Much time was spent on charges against doctors for unprofessional conduct and against county societies for admitting such undesirables as members. The Committee on Ethics was busy settling even such petty affairs as brawls between members. Dr. Sloan's presidential address on Anthropology was the farthest removed from discussing medical problems but revealed the most erudition outside of purely medical topics. There were but three other papers read.

1865. Reflecting the intense animosities engendered by the war just concluded—a resolution was adopted describing the Confederate Army as shameless rebels and Jefferson Davis its venomous chief as a craven, dotard and coward. It further execrated the criminals who assassinated President Lincoln and this resolution was adopted unanimously with emotions at high pitch.

1866. In this year and in several subsequent years, while the meetings were held and the Transactions published, no actions were taken worthy of comment in this brief history.

1867. A member was expelled for reading a paper on the progress of medical science when it was discovered to be an exact copy of an address delivered by a New York doctor at the New York State Society meeting the year before.

1868. Under the Constitution, the county societies were designated as auxiliary societies and

several of them objected to paying state society dues after they had paid their county society dues and insisting that this was double taxation. After interminable wrangling, the case was decided against them. (Much ado over an extra two dollars a year.) Dr. W. H. Wishard proposed a State Hospital for indigents, but met with fierce opposition from outside of Indianapolis. The next year nevertheless, the Society sent a memorial to the Legislature asking for it.

1870. The total annual income was \$206, expense, \$196, leaving a balance of \$10.00. Doctor Hibberd of Richmond exhibited an instrument which he just brought back from Paris, the pneumatic aspirator for the treatment of abscesses.

1871. There was an exceedingly long article on "Self Pollution in Children," picturing in the most ghastly and lurid phraseology the horrible effects of such a bestial practice. Dr. G. W. Mears presented a biography of Dr. J. S. Bobbs. The association unanimously expelled Dr. Daniel Meeker, a former president, for issuing a pamphlet claiming to have a secret remedy for the cure of opium eating and deriding the profession and the Code of Ethics. There were twenty-five committee reports on special diseases and remedies. The railroads allowed one-half fare rates.

1873. A proposal to meet in three sections was referred to a committee but it never reported. It was recommended that Indiana University establish a medical department.

1874. The Transactions contain a "Medical History of Indiana," by Dr. Thad Stevens, describing the early medical colleges, hospitals, and early medical societies, particularly the Indiana district medical societies—one of which was organized in 1820 and met in Corydon. Supplied by local authors were histories of Vincennes, Terre Haute, Allen County, Rush County, Noble County, and Hancock County. The full court proceedings of a trial to collect a doctor's bill was given space. A paper by Dr. James Thompson was illustrated by four pages of eye grounds in color.

1875. A continuation of the history of Indiana by Dr. Stevens including a history of Elkhart and Grant Counties.

1877. Governor Thomas Hendricks (granduncle of our Tom) was thanked for being the first governor of Indiana to recommend a State Board of Health. As the latest development in medical progress, a plaster of paris body cast was exhibited.

1878. We find the first mention of a medical defense fund to aid a doctor in a malpractice suit. The Allen County Medical Society raised such a fund but in defending two well known local physicians, they entailed an expense of \$420 more than they had available. They asked a contribution from the State Society on the grounds that the affair was the concern and interest of every doctor. The Society voted \$200 but it was never paid

and subsequently, voluntary contributions raised a part of it.

1879. The record reveals that county societies were being organized, disbanded, reorganized, recognized and not recognized—a pandemonium of organizational chaos. However by the next year, 1880, order was restored and even the American Medical Association admitted that Indiana was one of the best organized states in the Union because it insisted on the county society being the important unit. There were many papers proposing bills to regulate the practice of medicine and using a project, first mentioned in 1878, of establishing a State Board of Health. This was finally accomplished in 1891. The treasurer gave the total annual expense of \$857 of which \$113 was the cost of the annual session. The president deplored the expenditure of \$600 for publishing 1,000 copies of the Transactions as he said they were little read even by the members and soon discarded. In view of the failure the State Association has had in securing a complete file he certainly told the truth about their being discarded. He condemned the policy of county societies sending delegates to the American Medical Association as they should be selected by the state society only. Dr. Theophilus T. Parvin of Indianapolis, professor of Obstetrics at the College of Physicians and Surgeons, was elected president of the American Medical Association and so was the first Indiana doctor to attain that distinction. A few years later he removed to Philadelphia. His presidential address was characterized as the most learned document presented by any president up to that time.

1880. Doctor Beck of Fort Wayne wanted to levy \$1.10 per member to be paid to the family of a deceased member as doctors were notoriously poor.

1881. President Harvey's address observed that the germ theory is still problematic but in a paper by another essayist, it was stated that the cause of contagio-miasmatic disease must be found out, and it would probably be a living moving animal organism. A paper denouncing tobacco even contended that it was always concomitant with self-abuse and caused a long list of diseases including consumption and cancer. The State Society fostered a bill to regulate the practice of medicine in 1879 and it was re-introduced in 1881. The bill was promptly emasculated and later killed. Other bills met death in 1883. It was announced that at the last meeting of the American Medical Association, Indiana was led in attendance by one state, New York. Two Allen County Medical Societies showed up, each demanding recognition. After an acrimonious debate the oldest society was recognized. A paper was read by Mrs. Dr. Mary F. Thomas and the only justifiable objection to it was that she was a woman. Later in the day a resolution was offered to the effect that this society is not opposed to the medical education of women, but it was lost on vote.

1882. A speaker boasted that only two other states in the union published more Transactions than Indiana. These books are tedious reading however, for every remark made by everyone present is printed verbatim, making a lengthy volume—dull or interesting, depending on who was talking.

1883. A survey of Indiana showed that there were 5,376 doctors, of which 2,944 were regulars, 120 homeopaths, 480 eclectics, 106 physiomedical and 1,721 made no claims whatsoever. Of these, 2,056 were not graduates from any school and 48 could not even write their names. Also there were 304 registered midwives.

1884. A motion was barely lost which would have discontinued the Transactions and made the *Indiana Medical Journal* the official publication.

1885. Still every session was burdened with complaints about disreputable conduct of even prominent members. The Society reprimanded such contentions and told counties societies to police their own membership at home and not bring the matter to the annual session. The exhibitors generously took up a collection and paid the society the magnificent amount of \$25 for the privilege of exhibiting their wares.

1887. The Society was having program pains. A member would appear with a paper that was not announced until the time of the meeting. Some men insinuated papers into the list when they were not members of their county societies. A plea was made for having a printed program in advance. On account of expense there was objection to printing so many papers in the Transactions and some one said no better plan could be devised to insure that they would never be read.

1888. The 39th annual session will go down in the annals as the most memorable—certainly to that date. For the banquet, James Whitcomb Riley, our own Hoosier poet, wrote the original and apropos verses to each toast, and he responded with the premier reading of his now celebrated poem, "Doc Sifers." Bill Nye could not be there but sent a characteristic telegram, "Sorry I cannot be there. May you and your associates continue to take life easily as heretofore." Concluding the seventeen speeches the meeting "adjourned at three o'clock and four minutes, a.m."

1890. A whole county society was expelled because the majority of the members were physiomedicals and eclectics.

1891. Doctor Smythe's presidential address was on "Heredity" and he advocated the elimination of all criminals, degenerates and defectives so that a pure strain only could be propagated. (Dr. David Starr Jordan, president of Indiana University, later wrote a book showing that wars operated exactly in the opposite fashion.) Such radical views divided the assembly into two camps, one

wanting to publish the paper in the most widely read popular magazines, the other wanting to have it entirely suppressed. The president himself said that presidential addresses were getting to be philosophical, classical and abstruse, and the custom should be abolished and the time devoted to scientific topics. Sure enough the next year, President Edwin Walker in his unusually short address dwelt on vital and practical improvements in the modus operandi of the society. Dr. A. W. Brayton presented a patient with Kaposi's disease, xeroderma pigmentosum, a rare condition of which there were only twelve previous cases reported in America. In the 1892 volume is a colored plate of the patient. This probably increased the cost of Transactions by a pretty penny but Dr. Brayton was the editor and felt that he had special privileges. The railroad surgeon, usually an outstanding man, was excoriated for doing contract work for next to nothing in addition to the honor and annual pass, while at the same time a lesser light was condemned for unethical underpricing if he made calls for less than the established fees. The argument was so embittered that a motion to adjourn immediately saved a most unpleasant situation. A resolution was adopted recommending four years' study and three courses of five months each before allowing a student to graduate in medicine.

1892. Doctor Elder, the secretary, suggested dividing the meeting into two sections, one medical and one surgical, with one session devoted to the administrative work. This was a preview of later developments, as was the appointment of a special committee on recommendations, contained in the secretary's report and the president's address—the first reference committee. A motion to meet the next year and inaugurate subsequent migratory meetings met with no approval. The sessions were held continuously in Indianapolis from 1866 to 1895—thirty consecutive times before it finally went to Fort Wayne in 1896.

1893. There was a case reported of suppurative appendicitis cured by calomel and sweet oil. (It was evident that the abscess ruptured into the bowel thus effecting the cure.) For the first time there were organized commercial exhibits. Previously the drug companies just came in and camped out on a purely voluntary basis with no payment for space. Such an innovation did not escape criticism as there was great complaint about the medicine and instrument vendors causing so much disturbance and monopolizing the time of the doctors. They tried to appoint a committee to disperse the offenders but with no success. Also there was much ado about the organization of the Indiana State Medical Temperance Association which was composed of our members and met concurrently, thus stealing much of our attendance. The motion to meet in sections was defeated on the grounds that all meetings should be for the general practitioners.

1894. The subject of inebriety and the establishment of a state hospital for alcoholics occupied a lot of time. (It was about the heyday of the Keeley Institutes.) A violent discussion ensued about migratory meetings which descended into personalities and recriminations. A Fort Wayne member charged that the meeting was held in Indianapolis as a device to encourage the outlying physicians to attend and at the same time bring in their patients to the Indianapolis specialists. Consequently the Indianapolis men were too busy in their offices seeing these patients to attend the scientific sessions and of the seventy-five papers read only a few were heard by the local doctors. On the other hand, it was claimed that previous migratory meetings were almost disastrous, while at the Richmond meeting the organization nearly petered out. Doctor Elder, secretary for the past fourteen years, resigned on account of ill health and was elected president. The honor came too late as his death occurred the next day, even before the end of the meeting. Doctor Bond, the vice-president, was proclaimed president just in time for him to announce adjournment. Dr. James F. Hibberd of Richmond was elected president of the American Medical Association.

1895. Until this time a list of papers read before the Society was printed and kept up-to-date each year but now Dr. G. W. H. Kemper prepared an index which enabled one to readily refer to both the scientific and executive actions of the Society. The treasurer's report was startling. Although a dollar had been collected from the well over one thousand members, the expenses were so heavy that at the end of the year there was a balance of eight cents. The major disbursements were \$700 for the Transactions, \$100 secretary's salary and \$153 cost of the annual session. There were forty-five papers read before the two days' meeting, all heard in a general session, compared to twenty-eight papers in 1947 divided among five sections in addition to the general session. Fortunately for the auditors many essayists read their papers by title and the same were ordered published (or buried as many said) in the Transactions. Dr. A. W. Brayton, the editor, was severely reprimanded for violating the constitution in publishing some of the papers in his own *Indiana Medical Journal*. His defense was that "Indiana medicine shed a glorious light around scientific darkness and he didn't propose to let the entire world suffer for lack of this effulgence." Dr. Theodore F. Potter started a campaign against proprietary medicines, with secret formulae, crying out that they were allowed to advertise in the best medical journals.

1896. Through an oversight at Fort Wayne, no stenographer was engaged and the discussions were reported as well as Doctor Brayton could take them down in long hand. Papers on "Diphtheria" still betrayed the confusion concerning its identity with membranous croup. There were

opinions pro and con about antitoxin and one essayist relied entirely on intubation. Many papers on the treatment of infections and contagious diseases disclosed the abysmal ignorance concerning the causative agent. Groping in the dark they blindly struck out against an enemy unseen but vaguely suspected. The financial structure was eased to the extent of having a one dollar balance in the treasury.

1898. In President W. N. Wishard's address he stated that among state medical societies, Indiana was third, trailing only Pennsylvania and Massachusetts. The first annual report of the State Board of Medical Examination and Registration held the spotlight. The new law, a compromise affair with low standards in order to get it passed, naturally came in for a panning. Among its many defects, not the least was the fact that it did admit a host of irregulars, quacks and incompetents. Of the four thousand doctors licensed at least six hundred were mountebanks. Year after year a nominating committee came out with a slate which was seemingly adopted without nominations from the floor. This year was notable because it gave the meeting a new scientific feature, the pathological exhibit of 175 specimens. The ultimate importance of the idea is well told in Dr. Morris Fishbein's *History of the American Medical Association*. "Among the most significant and important developments of medical science has been the Scientific Exhibit. Today it occupies many thousands of square feet of space and has been characterized as the most valuable effort in behalf of graduate medical education attempted by any organization any where in the world. It started with small and simple beginnings. At the meeting of the American Medical Association in 1899, a resolution was introduced by Dr. Charles E. Slocum of Defiance, Ohio, in which he said that 'this Association hereby commend the efforts of the Indiana State Medical Society in preserving pathologic specimens and exhibiting the same at this meeting. This exhibit is worthy of the attention of every member, being a good example of what careful and persistent attention to pathology may accomplish in a short time when well directed. Such efforts are recommended to all societies as conducive to more careful and methodic diagnosis of treatment.' On motion this resolution was adopted. The exhibit had attracted so much attention in Indiana that the State Society appropriated \$300 to take the exhibit to the Columbus meeting of the American Medical Association. Dr. Frank B. Wynn urged a similar exhibit for each subsequent meeting and also the establishment of a section on Pathology. The Indianapolis Medical Society had been holding 'case history' nights once a month with the presentation of pathologic specimens. Dr. Wm. N. Wishard, president of the Indiana State Medical Society in 1899, requested Dr. Wynn to arrange a pathology exhibit at the state meeting in Indianapolis. So successful

was this venture that it was decided to show the exhibit at the meeting of the American Medical Association at Columbus, Ohio, the following week. Although nothing like it had ever been done before, a warehouse was rented in Columbus across from the Capitol building and the major portion of the exhibit transported from Indianapolis. Dr. Wishard bore most of the expense personally. More than seven hundred specimens were shown, accompanied by demonstrations."

It was reported to be "the most instructive feature of the meeting and worth a thousand papers." Dr. Wynn was made chairman of the newly-formed Section on Pathology and in his chairman's address in 1902 he outlined policies that are still in effect after all these years. He urged that personal demonstrations be promoted by the exhibitors, that it be kept free from commercialism and that a permanent medical museum be established.

1901. A paper on spinal anesthesia lies unheralded and unsung as far as the bibliographer is concerned for its title is "Medullary Narcosis."

1903. Dr. J. N. McCormack of Kentucky was retained by the American Medical Association to tour the country with the objective of reorganizing all state societies, standardizing their constitutions and writing and federating all of them to form the American Medical Association and with the county society as the ultimate unit. Doctor McCormack addressed the annual meeting, proposing the new constitution which was adopted and printed in the 1903 Transactions. The last printing of the old constitution was in the 1902 number and it had lasted for over half a century with only a few amendments. First, the name was changed from "Society" to "Association" although not every other state society followed suit. There was created an official House of Delegates. In the beginning, there were voluntary delegates consisting of one delegate to every five members in a county society. During this state, business was conducted between the reading of papers and when a vote was taken, it was often difficult for the presiding officer to recognize the delegates and charges were made that non-delegates packed the viva voce ballot. From now on the House of Delegates met in separate session with distinguishing badges, and to reduce its size the apportionment was cut to one delegate for every 100 members in the county society or major fraction thereof, providing that each county society was entitled to one delegate. In 1909 the number was changed to 50. Non-delegates did not lose their franchise entirely, as there could be a general referendum if necessary. To prevent rivalries between local factions, a physician could join the State Society only through a county society that had been legally chartered by the State Society. The magnitude of the work of the State Society caused the state to be divided into thirteen district societies with a councilor for each district.

These officers were appointed by the president for the first year but thereafter were elected by their respective districts. Such a Council was to act as a Board of Censors and as a Finance Committee with powers to act in the interval between annual meetings of the House of Delegates. Provision was made for dividing the annual session into separate sections. The offices of assistant secretary and librarian were abolished and the vice presidents increased to three. A serious mistake was made by denying the right of a delegate to be elected to office. It was designed to eliminate medical politics but later changed, as most delegates were exceptionally choice material. Also an officer could not be elected unless he was in attendance and had been a member for the past two years. No longer could county societies send delegates to the American Medical Association as they now must be elected by the State Association on the proportional basis. The new constitution was a model prepared by Doctor McCormack and was soon adopted by nearly all of the state associations. Dr. A. E. Bulson was chairman of the Committee on Reorganization and pushed it through in his characteristic vigorous and efficient fashion. This epochal revision marks the end of a definite era. Not only was the procedural and legal status changed but we were just emerging from the age of medical empiricism. The recent advent of physical and mechanical aids to diagnosis were revolutionizing the investigation and treatment of diseases. Therapy, from being a nebulous guesswork groping for a target, was becoming precise and specific. It was antitoxin versus purging and bloodletting. Even the scientific papers mirrored the transformation. Earlier addresses were disquisitions or speculations and now they featured the sphygmomanometer and the microscope with its revelations concerning pathogenic microbes and its disclosure of cellular pathology. The germ theory is no longer such but an incontrovertible and well documented fact. Abdominal surgery hitherto confined to ovariectomies, now blossomed with appendectomies, embellished with the logomachy as to when or whether to operate. Formerly essayists were handicapped by having such a small repertory of disease to discuss so they traveled and retraced the old trails of continued fevers, biliousness, dyspepsia, etc. Now compare the nosological tables of a recent textbook on medicine and note the multiplicity of diagnostic entities, with new ones appearing yearly.

1904 and 1905. The Transactions contained only a very brief report of the House of Delegates and no record of the scientific sessions.

1906. Dr. A. E. Bulson, secretary of the Council, presented an excellent report embodying many forward looking recommendations and suggestions that later came to fruition.

1907. Dr. George F. Keiper of Lafayette introduced the resolution that discontinued the

publication of the annual Transactions and established a monthly journal owned and published by the Council. The appointment of Dr. A. E. Bulson of Fort Wayne as editor and the progress of the *Journal* is related fully in another chapter of this book.

1908. The American Medical Association sent trained organizers to canvas the state and secure new members for the county societies. With the new *Journal* came the practice of printing the pictures of the officers for each year together with a biographical sketch of the president, a custom still continued giving a pictorial reminder of our leaders.

1909. For various reasons of climate, conveniences and vacations, it was decided to hold the annual sessions hereafter in September or October. At the Terre Haute meeting came the first smoker, or stag party, the night before the regular session. This fun section, a social affair, was designed to renew old acquaintances and make new ones under the stimulation of certain accessory items and under the relaxation from the more serious duties.

1910. The first official mention of any interest in medical defense came in 1909 when Dr. A. M. Hayden's resolution was adopted asking the president to appoint a committee to investigate the possibilities of establishing such a fund. In 1910 this committee composed of Dr. George D. Kahlo, chairman, and Drs. A. C. Kimberlin and A. E. Sterne made their report, in which it stated that actually "the experience of other state medical associations in which such a plan has been in operation has been not only a decrease in the number of suits for malpractice but an increased membership and interest in the association." The dues were raised from one to two dollars to include seventy-five cents for the *Journal* and seventy-five cents for the proposed medical defense fund but the total membership did fall off next year as a result. When Dr. Bulson was appointed editor of the *Journal*, he agreed to publish it at his own financial risk and furnish a year's subscription to each member for which the State Association would allocate seventy-five cents per member per year. While not specifically stated, it was understood that Doctor Bulson would take the chance of winning or losing, and it would be his business to secure sufficient advertising to make it pay. In 1910 and in many recurring years, some member would demand an investigation into the financial affairs of the *Journal*, but Doctor Bulson and his friends stood pat on the intent of the agreement and gave out no such report, claiming that it was of no concern to anyone so long as each member received a satisfactory journal which it undoubtedly was.

1911. The first working plan of Medical Defense was presented and adopted, and among the rules were that seventy-five cents of the annual

dues of each member shall be set aside for this fund but whenever the total fund reached \$6,000.00 the excess should revert to the general treasury. The administration was to be intrusted to a permanent committee elected by the House of Delegates. Doctor Kahlo served from 1910 to 1913. Dr. J. R. Eastman from 1913 to 1920 and Drs. Sterne and Kimberlin from 1910 to 1920. The total expenditure in any single suit should not exceed 25 per cent of the available funds. The liability of the Association should include only the expense necessary for the legal defense of its members and not damages awarded. A strict rule was made that a member is not in good standing and entitled to this feature until his county secretary shall have paid to the state secretary the annual dues. To aid the county secretary in this duty, the State Association began supplying each county with a triplicate receipt book for the collection of dues. This uniformity of receipt with triplicate consecutive numbering prevented disputes as the member and the State Association each received an exact copy of the transaction and this system is still in use to this day. The first suit defended was in 1912 against two Wayne County members. In 1921 the jurisdiction changed to the combined Committee on Administration and Medical Defense and the funds were transferred to the custody of the Association's treasurer. He was notified to limit the amount to \$6,000.00 with any excess reverting to the general treasury. In 1929 the Executive Committee assumed all responsibility. Many other states have since then incorporated medical defense into their activities but few if any have had as gratifying experience as Indiana. In spite of the increase in costs of every other phase of Association work, and contrasted with the increase in premiums of other insurance companies, the medical defense feature has remained at seventy-five cents per member for thirty-seven years. An attorney has been retained since the beginning.* Mr. A. G. Cavins served from 1912 to 1918; Mr. Chas. E. Henderson, 1918 and 1919; Mr. F. E. Shortemeier, 1920; Mr. Albert Stump 1928 to date. The income from 1912 to 1948 was \$76,779.00 and the expenditures \$50,423.83. On January 1, 1948 the fund had a balance almost of \$28,000.00. The records show that 263 suits have been defended and such a number in thirty-seven years would prove that Indiana has a remarkably low number of malpractice suits. From the above figures, the average cost has been \$191.72. For a detailed history of the fund from 1910 to 1932 one should read that written by Dr. A. F. Weyerbacher and Thomas A. Hendricks, a copy of which is in the executive secretary's file. On proper petition the House of Delegates granted a new section on Eye, Ear, Nose and Throat which held its first meeting in 1912. This new section was born quickly

* No record of an attorney being employed from 1921 through 1927.

and painlessly contrasted to the stormy incubation encountered by later proposed sections. Mention is made of the "Fourth Annual Conference of County Secretaries" but no record is found of the preceding three.

1912. The Committee on Venereal Diseases submitted a report recommending segregation and licensing of prostitution, and the heavens fell. The Indianapolis newspapers played this up on page one and the battle was on. From all over the state came brick bats with a few noseays. The House of Delegates wrestled with this ebullient controversy until a conciliatory and apologetic resolution was adopted in which the House declined to approve of any plan to solve the difficult problem. To expedite the work of the House all committee reports were to be printed in advance in the *Journal*, and thereafter many were adopted "as printed" without re-reading. Each section hereafter was to elect its own officers for the conduct of its meetings. The expense of the annual session had reached such proportions that it became a burden to the local society and it was voted that the Association pay all legitimate expenses and that revenue from the rental of exhibitors space be used to defray that expense.

1913. The dichotomy or secret division of fees was a major topic of discussion as a result of a lengthy editorial in the *Journal*. Letters were read from individual doctors decrying the evil, some villifying other colleagues, some protesting innocence and others still indignantly denying the accusation, and one of the most respected members reproachfully commented, "I did not expect to live to see the day when this Society would take up time discussing whether or not it was right to be honest." Several detonating resolutions were introduced and finally an amendment to the Constitution was agreed upon to the effect that "This Association does not countenance or tolerate fee splitting, division of fees or commission paying directly or indirectly and any member found guilty shall be expelled from membership."

1914. The Association appropriated money for a complimentary dinner to be given the secretaries who attended the Secretaries' Conference.

1916. The last three ex-presidents were made members of the House of Delegates and at a later date all ex-presidents were made members for life. Mr. G. V. Sheridan, executive secretary of the Ohio State Medical Association, addressed the House. He stated that Indiana was at the top of the list in three particulars; first, our *Journal*; second, our scientific exhibit and third, our successful medical defense fund. A committee was appointed to secure such an executive secretary for Indiana, the same to be not necessarily a physician.

1917. Mr. F. E. Shortemeier began his duties as executive secretary and had difficulty at first in convincing the county secretaries of a lay

officer's authority in requesting reports and replies. To enhance his prestige, define his duties and supervise his actions, a committee on Administration was formed, not appointive but elective. An abortive attempt was made to move the *Journal* to Indianapolis and combine the offices of the editor, secretary, treasurer and executive secretary.

1918. This was the war meeting with the subject, "Indiana in the War." The Medical Defense Committee resigned in accordance with the change of including those duties under the management of the Committee on Administration. The dues of all members serving in the Armed Forces were remitted and the Association agreed to pay for the *Journal* and the medical defense allotment out of the general funds. The Eye, Ear, Nose and Throat section held its first midwinter meeting.

1919. A motion was carried to exclude from membership any physician who sought by changing his location to profit by the patriotism of physicians who went to war. The list of standing committees was enlarged with appointments in staggered terms. The Committee on Hospitals was formed for the purpose of carrying out the mandates of the Council on Medical Education of the American Medical Association. Mr. Shortemeier resigned but was retained as attorney for Medical Defense and F. E. Raschig became acting executive secretary.

1921. The allocated part of the State dues for publication of the *Journal* was raised from \$1.50 to \$2.00. It had started at seventy-five cents in 1908. Each section was allowed to invite an out-of-town guest speaker at the expense of the Association.

1923. To better public relations, Dr. W. N. Wishard fathered the Bureau of Information which was later to be known as the Bureau of Publicity. This department, destined to become one of the most beneficial ventures ever undertaken, is described at more length later. It endeavored to make a most pretentious start, as \$7,000.00 was requested for the first year. To finance it, the dues were increased to \$7.00 annually.

1924. Dr. J. H. Stygall was selected as the executive or educational secretary for the new Bureau of Publicity at a salary of \$2,000, but resigned later in the year. As an additional attraction to the annual session, a postgraduate course of clinics and lectures was begun on the day preceding the meeting. And now came that innovation at first enjoyed and later endured, the seven a.m. scrambled egg breakfast for the House of Delegates at their final meeting. The original idea was to start early enough so that the delegates could finish in time to listen to the important scientific papers read before the last general session, but before many years the work had multiplied to such an extent that the House

rarely adjourned before noon. It required considerable incentive to assemble the delegates at such an early hour but that incentive was provided by making the first item on the agenda, the election of the next president. If there was any contest at all in sight each candidate's unofficial and unacknowledged campaign manager saw to it that his prospective voters were promptly seated. The public address in the Cadle Tabernacle given by Dr. Wm. J. Mayo was the largest attended in the history of the Association. It was in December, 1924 that the Association had the good fortune to secure as a full time executive secretary, Mr. Thomas A. Hendricks, a graduate of Princeton University and a feature writer on the *Indianapolis News*. He opened his new office in the Hume-Mansur Building and from now on, when troubles or problems arose, one was invited to "tell them to Tom."

1926. The finances of the Association had now reached proportions that required better accounting and a system of budgetary control was instituted under the direction of a separate committee. The revised constitution and by-laws omitted the vice presidents and substituted a president-elect, and Dr. George R. Daniels was the first to fill that office.

1927. Pondering over a few past embarrassing situations, the Association began employing a new device to prevent hasty or ill-advised legislation. It was decided that all resolutions or new business must be introduced at the first session and together with all committee and officers reports, be handed to a selected list of reference committees. These committees would scrutinize all prospective commitments, hold public hearings to listen to arguments by opponents or proponents and with well considered judgment submit their recommendations to the final meeting of the House of Delegates for ultimate action. To be appointed to one of these committees meant an added burden of time and energy, sacrificing meals and working far into the night to give due deliberation to the pressure groups that might have axes to grind. These committee men have the most decisive part in the work of the Association and are in a position to direct and guide all action to its terminal consummation. Announcement was made of the newly organized Woman's Auxiliary to the Indiana State Medical Association with Mrs. F. W. Cregor of Indianapolis as its first president. The minutes now show more and more opposition to state institutions doing work for patients able to pay and thus in direct competition with private practice. This was also true of the laboratory of the State Board of Health in connection with the Wassermann test. A charge was made that some general practitioners were sending blood to the State Laboratory and collecting a fee from their patients in spite of the fact that they were certified as indigents to conform with the law. A pertinent criticism was voiced against these

individuals and certain county medical societies were told that they would do well to police or discipline these recalcitrant ones on a local level. The Medical Defense Fund was relieved of a limitation in the amount of money on hand and hereafter was allowed to accumulate unspent balances in its own treasury.

1929. A motion was passed to initiate a department to prepare the Archives of the Medical History of Indiana with a historian appointed to serve during his lifetime, but alas to this date the Archives consist only of a miscellany;—but it is well cared for in the executive secretary's office.

1930. A large part of the record for three successive years concerned the work of the State Laboratory. The prominence of this controversy was a pregnant commentary on the long brewing of socialized medicine, involving the very foundations and sacred traditions of our profession. Allied to this topic was a motion passed a year ago which would allow the State Board of Health to seat a delegate of its own choice in the House. In the meantime it had been discovered that such an action contravened the Constitution and so a new amendment was offered to that effect. Of course the amendment had to lay over for one year and it was defeated the next year on the grounds that it would invite special interest to particular groups whereas the House of Delegates was intended to work only in the interests of the profession as a whole.

1931. Honorary membership was broadened to include all members who have reached the age of seventy-five and have belonged to the Association for twenty years or more. A motion to hold all annual sessions in Indianapolis was defeated although as will be seen fifteen years later, circumstances achieved the same end for no other city except French Lick could provide a sufficient number of hotel rooms and a sufficiently commodious space for session meetings and the exhibits.

1932. The untimely death of Dr. A. E. Bulson necessitated the selection of a new editor of the *Journal*. The Council named Dr. E. M. Shanklin and for the first time created an Editorial Board of five members to assist the editor. Thus the *Journal* has had but two editors, Dr. Bulson 1908-1932 and Dr. Shanklin 1932 to date. This and the succeeding depression years saw a decline in membership and a loss from investments so that the treasurer's report ended in red ink for the first time in many years.

1933. A motion to create a speaker and vice-speaker of the House of Delegates was lost. Indicative of resistance to the inevitable was the condemnatory resolutions against group hospital insurance and the proposed annual registration fee, as action on both of them were later conceded.

1934. Much fretting and fuming about the expert medical witness and the evils involved ap-

peared yearly as different topics loom up. We watch the kaleidoscope and marvel at the play and interplay of medical thought and opinion. As one reads the proceedings of the House of Delegates during the past twenty years, one notes the increasing prominence of the economic and sociologic impacts upon the profession, and the impromptu remarks of different members, reported verbatim by the stenographer, are most illuminating in depicting the actual motivations that impel the physicians.

For some reason or other that must have seemed good at the time, a statistician was appointed. After his first year's report the enthusiasm for computations of this sort waned and the office was soon declared vacant. A group of thirty anesthetists petitioned for a section on Anesthesia. Unlike the speedy acquiescence accorded the Eye, Ear, Nose and Throat section, this request sailed through stormy waters. The reference committee while conceding all the premises upon which it was based, advised rejection. The anesthesiologists having been forewarned, re-canvassed the delegates with such fervor that when a substitute amendment was offered it was passed overwhelmingly.

1935. Socialized medicine was being debated in the high schools and papers were read in Women's Clubs and Service Clubs so that it was thought wise to prepare a syllabus or hand book for speakers and writers who endeavored to present the doctor's side of the issue. Viewed in retrospect it looks as if a lot of unnecessary time was spent in deciding whether to codify the Constitution and By Laws or entirely rewrite them. Birth control or contraception, always a touchy subject, was introduced and as usual the delegates side-stepped, straddled and then irresolutely dodged by ordering a committee to make further study of the moot point.

1936. The perennial bone of contention concerning a registration fee was bandied about and again met a deaf ear. The annual midwinter Secretaries' Conference had advanced from a small unit to one of major dimensions and importance and supplied the best talent in the country to address the county officers. Dr. L. G. Zervas published twelve monthly articles in the *Journal* on "Indiana Medicine in Retrospect" to be used as the basis for a book but to date it has not been published. The topics covered the proceedings of the First, Second and Third District Medical Societies, milk sickness, and the biographies of eighteen pioneer physicians with case reports from their diaries.

1937. The Federal Government's grant of a considerable sum of money to the State of Indiana for the care of crippled children opened up new problems which envisaged further centralized regimentation of the physician. The proposal for a section on Gynecology and Obstetrics was refused

consent as was the motion to revive the office of vice-president. No progress was made in the effort to prorogue the dues and it was tabled. With the report of the Committee on Syphilis Control, the old battle between the State Laboratory and the private pathologist was renewed with vigor. To ameliorate the situation, the pathologists agreed to reduce the fee for the Wassermann test from five dollars to one dollar.

1938. A special committee appointed by President E. D. Clark to study medical education in Indiana made a voluminous report based on an American Medical Association survey in which Indiana ranked very low on the list of 77 acceptable medical schools. The small percentage of full time professors and especially the divided course at Bloomington and Indianapolis was a major factor in this uncomplimentary rating. The committee expressed confidence in the manner of accepting freshman students, which was an answer to the criticism that Indiana students were sometimes refused admission to the advantage of out-of-state residents. It was thought that 4.9% per year of non-residents was not objectionable. The State of Indiana was condemned for not financing the medical school to the extent of other states and advised to give all four years' course at Indianapolis. The report evidenced the great amount of time and labor incident to investigating the subject. Many of the facts found were of a confidential nature but the conclusions and recommendations as given to the House of Delegates were approved and adopted. The "Indiana Plan of Preventive Medicine" was read in detail as a sort of immunity against the evils existing in the national medical situation;—a plan that had already met with a nationwide recognition that had brought Indiana into the foreground of prominence. The House of Delegates noted that it was time now to put it into practical use. The Woman's Auxiliary, despite some opposition, was accorded the privilege of approaching various county medical societies for the purpose of establishing active units therein.

1939. Two gavels have been presented to the Association, one last year by Dr. S. S. Frazier of Angola, made of thirteen different woods, one from each of the Councilor Districts, and the other in 1941 from Dr. William E. Amy of Corydon, made from the Constitutional Elm at Corydon, the handle of which came from the farm of Governor William Henry Harrison. The dues were raised to \$10.00 to enable the Association to pay all of the expenses of the annual session, to pay all committee members for their expenses and employ additional clerical help in the headquarters office. Endorsement was given to non-profit hospital insurance and thus was paved the way for the Blue Cross which came in 1944. An extended discussion ensued on the annual registration fee. Leading delegates took opposite sides and it was diffi-

cult to decide who had the best of the argument. Some suggested that since the money would come out of the same pocket why not use the increase in dues to pay some group to ferret out illegal practitioners and prosecute them from State Association funds. Dr. W. U. Kennedy was appointed director of Research on Sickness Insurance and started the work which culminated in the Mutual Medical Insurance Inc. in 1945.

1940. Only at rare intervals does the House of Delegates go into executive session but it was necessary at this time in order to receive "top drawer" reports on the attitude of the forthcoming Legislature and its bearing on an expected attack from the cultists. Also under the seal of secrecy were presented plans for the extermination of medical charlatans. World War II threatened to engulf the United States and the subject of preparedness was on all lips. Indiana was well in the vanguard in setting up M-Day (Mobilization) Committees in each of the counties. The Governor allowed the medical profession to select its own list of designated examiners and advisory board members who were to pass on the thousands of inductees soon to undergo their physical tests. The director of Research on Sickness Insurance was commended for his comprehensive and penetrating analysis but there still was that lack of decision between the "medical service" versus "cash indemnity" plans and nothing further was accomplished except to recommend that the Council take such action as may be deemed advisable to advance these purposes. The Association voted to remit, for the duration of the service, the dues of all members called to the colors.

1941. Even though unaware of the fact that a declaration of war was but two months off, serious attention was given to the proposed Procurement and Assignment Agency which would control the destiny of nearly two thousand doctors in the state. It could decide who should stay in civilian practice and who should enter the army. It could designate one doctor as indispensable to his community and another one to leave his home and practice. In its preparedness program Indiana was conspicuously in the lead. All plans for sickness insurance were shelved for another year.

1942. The influx of refugee physicians from Europe prompted a resolution asking the State Board of Medical Registration to uphold the strictest requirements in that the licensee should have full citizenship in the United States. Tom Hendricks, the indefatigable executive secretary, divided his time between Washington and Indianapolis and also assisted Dr. Charles R. Bird in the huge task of getting 1,400 doctors into the service without depriving the civilians of their essential medical needs. In reading all of the bulk of material incident to writing this chapter, nothing was more interesting in retrospect than the committee reports on two paramount topics, mobilization to win the

war and sickness insurance. They cannot be abstracted in a way to reproduce the intensity and serious consideration given by already overworked members. These reports must be read in their entirety as printed in the *Journal* where they stand as imperishable documentary evidence. The director of Research states that "The War effort has nearly smothered clamor for state medicine although here and there a voice seeks to turn our presently limited medical service into argument for extension of publically controlled health service." In the meantime, nothing could be done until such day as there could be formulated a plan acceptable from the legal, professional and economic standpoint.

1943. The Industrial Health Education Program was a major activity, concerned with improving the work of industrial surgeons, in supplying better medical care to employees and in fostering more cooperation between industrial and non-industrial surgeons. Under the Maternal and Child Health Department of the State Board of Health, the federal government supplied funds to furnish free medical care to wives and children of enlisted men. The Association agreed to the principle but objected to rendering services where recipients were able to pay. The subsequent history shows that in spite of the protest such restrictions were never enforced. While this scheme will terminate six months after the duration, for the time being it is another step in federal domination of the practice of medicine. Because of its popularity, the Association could do no less than acquiesce to the mandate no matter how unpalatable. A host of resolutions were introduced, all proscribing the Murray-Wagner-Dingell Bill which could burgeon into a federally controlled system of medical practice under the virtual dictatorship of the Surgeon-General of the Public Health Service. Some of these resolutions were vehemently condemnatory of the American Medical Association for its languid inactivity and lack of a definitive counter proposition. The hostile delegates were warned that their accusations would certainly be "aid and comfort" to the enemy. Others, critical though they were, contended that the resolutions should be passed as they believed that the American Medical Association was really only waiting for such instructions from the grass root counties. Memory recalls that forty years ago Drs. A. E. Bulson, J. H. Weinstein, et al. prophesied socialized medicine, but whereas then the admonition fell on unheeding ears now with S. B. 1611 sending its hot breath down our necks, everyone wanted something done about it. After a protracted debate, the annual registration fee received fairly unanimous acquiescence and so ended a schism that had plagued the Association for many years.

1944. This meeting was held in conjunction with the Army Air Force Medical Service with a Vice Admiral, a Brigadier General, a Major General, a Colonel and several Majors on the program. The monthly "Medsoc" letters directed to the 1,260 In-

diana doctors in service received universal commendation and several other states copied the idea. The Executive Committee adopted a group policy covering medical practice liability and an insurance company was designated as the official underwriter for such malpractice coverage, a policy now carried out by sixteen other states. A war time assessment of \$5.00 per member per year was levied beginning January 1, 1945, for the duration of the war and one year thereafter in order to pay the dues of those in service without depleting the treasury. A centennial committee was appointed to arrange for a celebration of the one hundredth anniversary of the founding of the Indiana State Medical Association with Dr. Charles N. Combs as chairman. In 1948 Dr. Edgar F. Kiser was appointed co-chairman. The report of the Committee on Lay Domination in Medical Practice surveyed the field and advised, among other things, that we start at once a vigorous fight to hold or regain control of hospitals and that the law be repealed which limits membership on the Boards of County Hospitals to laymen. Also it desires the creation of a Section on General Practice. Adjournment was taken with the intent of meeting again before 60 days for the purpose of reaching a final decision about the health insurance plan. Now for the first time in the history there was a special midwinter meeting on November 12, 1944. There were 114 members of the House of Delegates present, which qualified the meeting as being as representative and authoritative as any regular annual meeting. Most of these delegates left home with positive instructions from their county societies as to how to vote even though as it happened that such a vote did not always reflect their personal opinions. The minutes of this meeting spread over forty-seven columns of fine print in the *Journal* giving the detailed vote of each member in each motion. The order of business was the motion to adopt the Reference Committee's report on Health Insurance offered in the October, 1944, session. Dr. F. S. Crockett, chairman of the Committee, re-read the report and then submitted its substance in four motions:

1. Approval of a pre-payment plan of health insurance. Carried by a vote of 66 to 33, but many of the latter number thought that no vote should have been taken while the younger men were in the service.

2. Approval of a non-profit mutual indemnity type of insurance. Carried by a vote of 53 to 45.

3. The plan to be organized and operated by members of the Association who have been selected and appointed by the president with the advice of the Council. An amendment was offered which added the words "or directed" so that the motion would read "organized and operated or directed by members," etc. Amendment lost by 47 affirmative and 49 negative. Original motion lost by 42 yeas and 56 nays.

4. The president with the advice and approval of the Council to appoint a committee to carry into effect these provisions. Amended to read that there be no operation until the contracts were submitted to the House of Delegates for approval or rejection, before a vote was taken. By a vote of 80 to 17, the motion No. 2 was reconsidered and it was carried after deleting the words "non-profit" and "mutual." Then a motion prevailed that the Association approve of an indemnity type of health insurance. The final action was to order a new committee appointed to work out an acceptable plan, to be submitted to the House of Delegates before final approval and that another special meeting be called for that purpose. The end result of all this oratorical juggling at least gave every member a chance to air his views, but the lack of unanimity deferred progress again.

1945. This, the "Peace," or "Victory" meeting, was scheduled for October, but federal regulations prohibiting conventions or assemblies on account of limited travel facilities caused it to be postponed until November and indeed only on a marginal decision was it allowed to meet at all. A fifth section on General Practice was added, as the current trend against over-specialization made it a popular issue. Tom Hendricks was loaned to the American Medical Association for part time work on the Council of Medical Service and Public Relations and Ray Smith was made assistant executive secretary on June 1, 1945, but with the understanding that he give part of his time in continuing his work as executive secretary of the Indianapolis Medical Society. It was voted to terminate the \$5.00 war assessment with the year 1946. A proposal to join with the Indianapolis Medical Society in erecting a permanent home was looked upon as desirable, but was referred to the Council for evaluation of the cost. The returning veteran with all of his problems of readjustment and rehabilitation was given primacy over all other topics. Ex-service medical men had their peculiar grievance in that during their absence other doctors usurped their office space and refused to vacate. The Committee on Post-War Medical Service after scanning the distribution and location of physicians in Indiana found the assimilation of returning medical veterans a tough nut to crack by any formula and so recommended action by each county society on an individual basis. A poignant feeling of dissatisfaction spurred the veterans into holding their own convocation which almost amounted to a rump congress. A spokesman for this potentially powerful group presented their requests to the last meeting of the delegate body asking (1) for a Service men's Section, (2) that the County Procurement and Assignment Service Committees be responsible for the welfare of the returning doctor and (3) that a loan fund be available for the benefit of needy veterans. The report was adopted and loans up to \$500.00 at 3% interest were authorized. The creation of a Board of General Practice was un-

doubtedly an innovation as a duty of the Association. The Board was empowered to conduct examinations and issue certificates of proficiency as a means of holding and further attracting the best doctors into the field of general practice and giving them tangible evidence comparable to that granted by the specialty boards. The president was directed to appoint fifteen members, one from each Council or district, one at large, and the faculty of the Indiana University School of Medicine was to name the fifteenth member. The first two hundred acceptable applicants were to be exempted from examination and were called "Founder's Group." At present certificates have been issued. As a comment on its multifarious duties, the Council will henceforth hold three meetings during the year—January, April and July—instead of one, and the Constitution was so amended. An entire day was allocated to another special meeting, the single agenda of which was prepayment medical and surgical care. The new committee of twenty-one members supplanted all previous ones and made a fresh contribution to the subject, and after its lengthy report, which encompassed all of the divergent view points, offered this concise motion: "That the medical insurance plan shall be of the mutual medical service type." Then ensued amendments, amendments to amendments, and substitutionary motions, and after the parliamentary tangle was resolved, a final motion carried which changed the words to "an indemnity type of insurance." The Council was again ordained to carry out this directive resolution and again the next day the deliberative delegate voted to have the Council resubmit it at a future session for final approval. For seven years these county plenipotentiaries had wrestled with the insurance plan and still they had not mastered it.

1946. A third special meeting of the House of Delegates (the second midwinter meeting) was held January 1946 to terminate if possible the impasse. Before doing so, the House listened to a report on the Hill-Burton Bill which granted federal aid in the erection of non-governmental hospitals, and no objections were forthcoming. What was probably the last invitation (that from Fort Wayne) to meet in a city other than Indianapolis or French Lick was declined due to inadequate hotel facilities and thus in the foreseeable future all annual sessions will have to be held in these two localities notwithstanding the fact that by far a majority of the members live north of the U. S. Road 40. The Veteran's Administration plan for medical care was spread before the assembly involving such questions as (1) non-service connected disabilities, (2) treatment by civilian doctors, (3) treatment in other than veteran's hospitals, (4) a fee schedule whether fixed by the Veteran's Administration, the State Medical Association or by each local society. The only motion evolved was that the county societies have a voice in any fees established. Then Dr. W.

U. Kennedy read the final draft of the Articles of Incorporation of the Mutual Medical Insurance Co. Inc. and for once the vote to adopt was unanimous.

1946: The Annual Session. Indiana was signally honored when Tom Hendricks was called from his position with the State Association to become the secretary of the new American Medical Association Council on Medical Service and Public Relations, leaving May 1, 1946. This promotion recognized Tom as premiere among state secretaries in that he had spark plugged the Indiana profession into leadership throughout the country in morale, public relations and general achievements. Nothing could ever erase our affectionate memory of him, but to signify our undying admiration he was given the unique honorary title of Executive Secretary Emeritus. The first accounting rendered by the Mutual Medical Insurance Company Inc. showed that with but eight weeks of operation the Company stood ninth in the United States and at that rate of growth would be fourth by January 1, 1947. The development has been unbelievably rapid testifying both to the public acceptance and need, and moreover to the soundness of the plan. Representatives of both Houses of Congress stated that we were demonstrating the desire and ability of the medical profession to meet the demands of the public and so were fortifying them in opposing socialized medicine, by concrete proofs of our intentions and capacity. This doctor's insurance is operated by integration with the Blue Cross Hospital Insurance, sharing the same office space and overhead and using the Blue Cross organization to solicit members and collect payment. More than seven hundred members of the Association advanced sufficient money to launch the doctor's insurance with the knowledge that if it failed all of their investment was lost. Their trust was rewarded with the repayment of all advancement certificates as of February 1, 1948. The triumphant burgeoning of the insurance plans has not been without opposition from the pathologists, roentgenologists and anesthetists whose fees are the most closely interwoven with hospital bills. Their fears proved groundless since instead of fixing or limiting their fees, these specialists have been allowed to determine their own charges and even if the contract does not always cover the entire amount, they were allowed and did collect the extra amount from the patients. Further autonomy will soon be reached when their fees will be transferred from the Blue Cross to the Doctor's Plan. The Service Men's Section presented resolutions covering any future national emergency and employment of veterans as consulting civilian doctors in the Veteran's Administration and both were passed. The shortage of nurses loomed large and there was variance in the matter of how to remedy it. The proposal for short term courses was not approved as it would not meet with favor from nursing school faculties. To decrease the tuition

or increase the salaries of graduates might attract girls on a mercenary basis. Sentimentality overruled practicality since glamourization in the recruiting campaign seemed to be the only possibility. The president created a Council on Medical Service and Public Relations whose function would be to cooperate with the parent Council of the American Medical Association in furthering its objectives on a state level. This Council adopted a pretentious program of twelve points designed to support and implement the American Medical Association's ten point program. The next year saw this Council changed to a Committee on Public Relations. The first meeting of the Section on General Practice was highly satisfactory under the chairmanship of Dr. J. T. Oliphant. The annual dues were raised to \$15.00. The registration at Indianapolis attained the new high of 2,240.

1947. Three new sections were petitioned for, and the one for Gynecology and Obstetrics was granted, while the ones on Industrial Medicine and Health and on Diseases of the Chest were refused. The Association sponsored legislative action to require the informatory suffix M.D., D.D.S., etc., where a prefix of Doctor was legally used. The president recommended that the offices of vice president and speaker of the House be added by constitutional amendment. This energized the opposition met with in previous years but after the debate it was accepted as an amendment but to lay over one year before final action. By reason of a low mortality rate the Association has accumulated a list of twenty-one living ex-presidents and seventeen of those dignitaries were at the meeting. Janus-like, the Association looked forward and backward at this meeting. It discovered that there were 204 members who had practiced medicine for fifty years or more and formed a "Fifty Year Club." At the banquet there were about forty of the old timers in attendance who with lively pride and satisfaction received the certificates and badges conferred upon them. Looking forward, the Association granted four scholarships of \$500.00 each to medical students who in return would agree to practice in a rural community for five years subsequent to graduation. Money was appropriated to present three gold keys to the three students achieving the highest senior grades. Six scholarships of \$200.00 each were likewise awarded to deserving student nurses throughout the state. Added to all this concrete activity in promoting internal and external better relations, was a year's subscription to *Hygeia* given each member of the State Legislature. The session ended on a high note in celebrating the election to the presidency of the American Medical Association of Dr. R. L. Sensenich, a distinction accorded Indiana for the first time since 1894.

1948. The session held at Indianapolis set a new record for registration, 2,681 persons, of whom 1,436 were members. With a new proposal for

alternate Councilors, the revision of the Constitution and By-Laws was delayed for still another year. Due to ill health Dr. E. M. Shanklin, editor of the *Journal* for the past sixteen years, was elected Editor Emeritus. His associate, Dr. Frank B. Ramsey of Indianapolis, was elected as editor and Dr. A. W. Cavins of Terre Haute was made associate editor. Other officers were re-elected and Dr. Claude S. Black of Warren, with a record of long outstanding service in the Council, was unopposed as president-elect.

Dr. David D. Oak of LaCrosse was selected as the outstanding general practitioner and thirty-eight new members were initiated into that select and exclusive group called the "Fifty Year Club." All efforts now focus on the centennial meeting next year which is to be an elaborate and noteworthy celebration.

These brief summaries are merely the sign posts, indicating the directions, the turns and twistings of the road of progress. Sometimes a seemingly casual action or resolution foreshadows a major development later. Here we have a panorama or rather a drama of one hundred acts. We see the doctors make their debut, perhaps at first as supernumeraries. In the next act they are assigned a minor part and soon take a major role and then comes the year in which one occupies the spotlight as the president. After that he may continue his activity or "lag superfluous on the stage" until the final exit in the form of the obituary memorial and other dramatis personae appear and the play continues. Knowing the players of the last fifty years, the writer has resisted in the main the impulse to attach names to important events, trends and ideas, even though the originators were entitled to a full mead of praise. The mention of a few should in no wise be construed as a compliment to them in contrast to the many others just as deserving, for the list is long and impressive. While this review has concerned itself chiefly with the business transacted by the House of Delegate, one should not overlook the scientific program presented each year. Papers have been read by distinguished guests from the elite of the country. Of the multitude of contributions by Indiana doctors, some of them have been original investigations of notable caliber. For many years we have had the president-elect of the American Medical Association as principal speaker at the annual banquet. The scientific exhibits have increased in magnitude and importance. The commercial exhibit has kept us informed of the latest in pharmaceuticals and equipment. The social side of the meetings has furnished varied entertainment for the doctors and their wives. The golf, trap and skeet tournaments are indispensable in the eyes of their devotees. The reunions and group luncheons are further attractive features. The hobby shows of 1939-40-41 displayed the extra-curricular pursuits of the doctors, seeking relaxation and relief from an exacting practice. The annual banquet

with two speakers, one commenting on large national questions and one supplying the comic relief, together offer a varied diet to suit all tastes. In fact the two and three days are so crowded with activities as to make the meeting anything but a vacation. In 1925 the minutes of the House of Delegates were contained in five columns of fine print in the *Journal*, but for the past few years it has expanded to from forty-four to fifty such columns. Above this is the annual handbook consisting of the reports of officers and committees, the minutes of the Council and of the Executive Committee, all of which if bound together would constitute a tome of huge proportions, and without comment or abstracting would represent in itself a history of the Association far better than this one. However the real history is the fifty-nine volumes of the Transactions plus the forty bound volumes consisting of four hundred and eighty issues of the *Journal*. This chapter is simply a collection of such items as caught the fancy or attention of the writer in re-reading all of the above material. To comprehend the immense and significant changes occurring during the hundred years, one should peruse all of the above mentioned records, a task many will refuse to do and a pleasure that too few will take time to enjoy. The only complete file of the Transactions is in the Indianapolis City Library.

THE PRESIDENT

The ascent to this highest office is, to put it in lodge parlance, usually through the chairs. One may be first a county society officer and then be given a state committee assignment and finally be elected a delegate. Later he may become a counselor. The chairman of the Council or a member of the executive committee, by reason of his familiarity with the innermost circle, is in direct line of succession to the office. The successful nominee is almost always a well known wheel horse or a worker in the organizational and politico-economic field. The Council was formed in 1903 and of the last thirty presidents half of them have graduated from the council. Two treasurers and three secretaries, having served the Association for many years, vacated their offices to take the presidency. Not often is the crown unanimously offered to a doctor whose qualifications are solely by virtue of his professional and scientific attainments.

For a time the choice entailed geographical limitations, as by a gentlemen's agreement, of every three presidents one was to be from Indianapolis, one from the northern and one from the southern half of the state. The same triadic device was used in locating the annual meeting place.

The Association has endeavored in a way to box the compass in favoring the different specialties. Not pretending to be too exact in the classification it may be stated that out of the last fifty presidents there have been ten surgeons, nine internists, five E.E.N.T., two each of urologists,

proctologists, dermatologists and anesthesiologists, one radiologist and seventeen general practitioners. Of the latter, only half of them lived in small towns and were really family doctors. Twice both father and son were honored as in the case of Dr. Marshall Sexton in 1882 and his son Dr. John C. Sexton in 1899 and later in the case of Dr. W. H. Wishard in 1889 and Dr. W. N. Wishard, his son, in 1898. On six occasions the president did not preside over the annual session. On account of ill health or death he was unable to serve throughout the term and by a turn of fortune six other men unexpectedly inherited the title. In 1864 Doctor Sloan was sick for the entire year and Doctor Moffett, the vice president, officiated. By a strange coincidence the same thing happened in 1865 when Doctor Linton was ill throughout the year and Doctor Lockhart, the vice president, acted in his stead. In 1873 Doctor Casselberry died soon after he was elected and Doctor Hobbs, vice president, succeeded him. In 1879 Doctor Humphreys was in poor health all the year and Doctor Newland, the vice president, served *de facto* but not *de jure*. In 1895 Doctor Elder died the very next day after he was selected and Doctor Bond the vice president assumed the duties. In 1934 Doctor Leach died before serving very long and Doctor Sensenich, the president-elect, really held the position for two years.

Up until about fifteen years ago, the president had no onerous tasks aside from presiding over the annual session, attending a midwinter meeting of the Council, visiting an occasional district society and the appointment of committees. Now he has less and less to do with the "scientific" program and more with the enormous expansion of the committee and conference schedules. There is scarcely a day in the entire year devoid of medical society duties. In this same turmoil the president-elect is involved for a full year before his term arrives.

No one has sensed the situation more keenly than Dr. Floyd T. Romberger, president in 1947, and he expresses his views as follows:

"The routine duties and labors and the many essential contacts and necessary visitations of your association president during the year of his tenure in office have grown by prodigious leaps and bounds over the years, especially during the past quarter century. Time was when the office was largely an honor, always truly earned and deservedly granted; at present it is a real job, one which demands considerable attention and hard work.

"Many indeed are the ramifications of contact and influences of this great Indiana State Medical Association; yet the complexities and imponderables of today, in the matured judgment of many past-presidents of experience, will seem relatively simple when compared with the manifold problems to be met and solved fifteen and twenty years hence.

"One of the first tasks of the incoming in-

cumbent, and this must be done shortly after the annual session in October, for publication in the *January Journal*, is the selection and notification thereof of the members for the several standing and special committees. There are nine standing committees mandated by the Constitution and By-laws, and a varying number of special committees, as directed by the House of Delegates and the Council from time to time, usually twenty-five up even to as many as thirty-five and forty. In this, the president is assisted and counseled by the executive secretary and the councilors, giving due consideration to the geographic and professional distribution and also to the ability and willingness theretofore of the appointee to labor at the state level.

"On many of these committees the president is an ex-officio member, and of all he is the titular head and nominally responsible.

"In January comes the first Executive Committee meeting and the midwinter session of the Council, closely followed by the county secretaries' conference and the industrial health conference. The year really has begun.

"The Executive Committee meets every month, and the Council holds forth every three months throughout the year. These sessions frequently extend into many hours.

"During legislative years, when the Indiana General Assembly meets, the president contacts each individual member by mail and frequently is in conference with the Association Committee on Public Policy and Legislation, which committee carries the heavy burden along with the executive secretary.

"Also during every year, the president makes appearance before the microphone and contacts and/or visits with many allied bodies and associations: The State Dental Association, The State Bar Association, The State Pharmaceutical Association, The Grange, The Farm Bureau, The State Hospital Association, The State Nurses Association, The American Red Cross, The Foundation for Infantile Paralysis, The State Cancer Society, The Society for Crippled Children, The Tuberculosis Society, The State Board of Health, The Board of Medical Examination and Licensure, The Veterans Administration, Freshman Medical Students in Bloomington, Senior Medical Students at the Medical Center, The Post-Graduate Schools of General Practice and Otorhinolaryngology, and our own Woman's Auxiliary. Often there are others.

"During the year the president visits by invitation and appointment the thirteen medical districts of our Association to carry to them the story of organized medicine's activities in Indiana and to assist the councilors in their duties in building up the county societies as useful units of the Association.

"Monthly, the president presents his own personal feelings and ideas to each and every member

of the Association through his President's Page in our *Journal*.

"During the annual session, the president presides at all the general meetings of the Association, delivers an annual address on such matters as pertain to the welfare of the physicians and the organized profession of the state, presides as parliamentarian at all the meetings of the House of Delegates and appoints the necessary reference committees which do the work of the Association at these sessions, subject to the approval of the House of Delegates, visits the sections in session, honors the visiting speakers and distinguished guests, and acts as host and toastmaster at the annual banquet.

"In all these duties and functions the president ably is assisted by the president-elect, by the executive secretary and the headquarters personnel, by the *Journal* editors and the editorial staff, by the Executive Committee and the Council and by their respective chairmen, and indeed by the entire membership at large throughout the state. It is this unanimity of support to its leadership which has made and will continue to make our Association great."

OTHER OFFICERS

The vice-presidents have been officers by courtesy only, with the exception of the five who were fortuitously promoted. From 1849 to 1864 there were four vice-presidents each year, and then only one from 1865 to 1903 when the number was increased to three. With the election of a president-elect in 1928 the office was abolished but was revived in an amendment of 1947 to be voted on in 1948. Doctor Kemper's history gives the names of the incumbents from 1849 to 1912—one hundred and twenty-seven, but the names of the forty-five following ones have never been published in a separate list and the total is too extensive to be reprinted here.

The secretary and treasurer without expectation of honor or eclat, perform the routine, detailed tasks so essential to a smooth working organization. The roll of these officers has not been called heretofore and is now set forth.

Secretaries: J. S. Bobbs 1849-51, A. M. Hunt 1852-3 and 1856, Chas. Bowman 1854-5, T. B. Elliott 1857, Theophilus Parvin 1858-1860, Clay Brown 1861, J. M. Gaston 1862, W. B. Fletcher 1863-4, W. F. Harvey 1866, L. D. Waterman 1867. Thus far it is evident that the Association has been unsuccessfully trying to find the right man which they did in the next year. G. V. Woollen 1868-1880 (13 yrs.), E. S. Elder 1881-1894 (14 yrs.), J. H. Woodburn 1895-6, F. C. Heath 1897-1910 (14 yrs.), Charles N. Combs 1911-1924 (14 yrs.), Executive Secretary Thos. A. Hendricks 1925-1945 (21 yrs.), Ray E. Smith 1946-.

The secretary's salary or honorarium was \$100.00 per year until 1899. Then was added to it, ten

per cent commission of the dues. In 1904 it was fixed at \$300 and raised to \$500 in 1920. All this of course was when a physician member held the office as a part time job.

The annual dues were originally \$1.00 with an initiation fee of \$2.00. In 1859 the initiation fee was abolished and the dues were raised to \$2.00. Then back to \$1.00 in 1870, up to \$3.00 in 1872, back to \$1.00 in 1880 and up to \$2.00 in 1910 but this figure included 75 cents for the *Journal* and 75 cents for the Medical Defense Fund so that the general budget was meager until 1917 when the dues were raised to \$4.00. Then in 1923 to \$7.00, in 1940 to \$10.00 and in 1948 to \$15.00.

Treasurers: J. L. Mothershead 1849-50, 1852-57, D. Funkhouser 1851, C. Parry 1858, J. H. Woodburn 1859-65 and 1872-76, W. B. Lyons 1866-71, I. C. Walker 1877-79, G. W. H. Kemper 1880-86, C. B. Higgins 1887-89, F. C. Ferguson 1890-91, J. O. Stillson 1892-96, A. E. Bulson 1897-1910 (13 yrs.), D. W. Stevenson 1910-15, Charles N. Combs 1916-26, Wm. Doeppers 1926-31, A. F. Weyerbacher 1932- (17 yrs.).

Succeeding Tom Hendricks in 1946 was Ray E. Smith who likewise has endeared himself to the medical profession by his sympathetic understandings, his affable cooperation and by the intensity of his application to the objectives of the Association. He was raised on printer's ink and senses the true values of intelligent and dignified publicity. He was Governor Schricker's secretary during the years 1941-1944.

Far from the bottom of the list in point of indispensability, are the two members of the office personnel. Miss Lucille Kribs joined the staff in February, 1926 but after a short time finished her education at Indiana University and rejoined in April, 1928. In 1939 she was promoted to the position of assistant executive secretary and can stump the experts in answering any question about the Association. Miss Elsie Reid began work in November 1931 and as membership secretary, she knows the 3,500 doctors who belong, their names and pedigrees as a farm boy knows the cows in the pasture.

COUNCIL

Among the faithful few who have devoted so much time, energy and thought in molding the destiny and advancement of the Association none are more outstanding than that little band of thirteen councilors.

Some served but a short time, many served for a long term, and the list would be too lengthy to print. The acknowledged leader of this group is the chairman and that office has been held by the following members; William N. Wishard, Sr., 1903-13, William R. Davidson 1914-16 and 1924-8, G. W. H. Kemper 1917-20, E. M. Shanklin 1921-3, E. E. Evans 1929, E. E. Padgett 1930-1, O. O. Alexander 1932-6, M. A. Austin 1937-40, Floyd T. Romberger 1941-5, A. M. Mitchell 1946, Alfred Ellison 1947- .

COMMITTEES

It would be an unfair discrimination to say that any one committee did better work than any other, but the unique career of our Committee on Publicity would surely justify a recapitulation of its *modus operandi* as given herewith by Dr. Homer Hamer, its chairman.

"The development of the Committee on Publicity, known for many years as the Bureau of Publicity, was largely due to efforts of Dr. William Niles Wishard, Sr., of Indianapolis, who had the wisdom and foresight at an early date to recognize the need for better medical-public relationship. Appointed chairman of the original committee in 1922, Doctor Wishard served in this capacity until his death nineteen years later.

"In the early twenties the medical profession was annoyed and embarrassed by frequent appearances of misleading articles on medical subjects in the public press. Among those whose ethical sensibilities were deeply offended was Dr. John A. McDonald of Indianapolis, who introduced a motion in the House of Delegates, in session at Muncie, on September 29, 1922, for creation of a Committee on Public Education with a secretary who would, among other things, see to it that accurate information of a medical nature reached the lay public. Dr. David Ross and Dr. Frank W. Cregor, both of Indianapolis, were named to the committee with Doctor Wishard.

"The committee engaged Dr. J. N. Hurty, who had resigned as secretary of the Indiana State Board of Health in 1922, as 'educational secretary,' but illness prevented him from assuming his duties. As a consequence, the committee was forced to find another secretary, and Dr. James H. Stygall of Indianapolis, who was then leaving the medical directorship of the Indiana Tuberculosis Association to enter private practice, was engaged on a half-time basis. Doctor Stygall assumed the position January 1, 1924 and opened an office in room 1004, Hume Mansur Building, Indianapolis. Up to that time the Association did not have an office or any paid employees. Mrs. Louise Gillespie, of Indianapolis, was employed as stenographer. The committee spent \$416.95, which included the cost of a typewriter, to equip the office.

"In a lengthy report to the Council on December 28, 1923, Doctor Wishard outlined a working basis for 'the publicity education it is undertaking.' It was a very ambitious program, even for this day, and included press releases, talks on public healths before lay groups by speakers supplied by the bureau, encouragement of county medical societies to have more frequent and better speakers at their meetings, supplying literature and information to county medical societies, etc. Radio was not far enough developed at that time to be a medium for dissemination of information.

"Doctor Wishard told the Council that 'better examinations, better diagnosis and less secrecy in medicine should be emphasized to secure a more

sympathetic understanding by the public of the profession's purposes and work.' This purpose enunciated by Doctor Wishard that day, more than twenty-six years ago, is the essence of modern-day medical public relations.

"Doctor Stygall entered into the planned program with enthusiasm, setting up a speakers' bureau, preparing news releases on scientific subjects and, in company with Dr. Samuel E. Earp of Indianapolis, the 1924 president of the state Association, visiting many county medical societies throughout the state. However, Doctor Stygall's practice increased as well as his volume of work as bureau secretary, compelling him to resign December 1, 1924, so that he might devote full time to his patients. He had the honor later to serve six years as a member of the committee.

"For the third time in two years the bureau found itself without a secretary. Experience gained during 1924 convinced Doctors Wishard, Ross and Cregor that a man with newspaper background although not a physician was preeminently qualified for the secretary's work. After interviewing several prominent Indianapolis newspaper men, Thomas A. Hendricks, a member of the editorial staff of *The Indianapolis News*, was employed as executive secretary, a position he was to fill for more than twenty-one years. Dr. Charles N. Combs, of Terre Haute, was secretary-treasurer of the state association at this time. Mr. Hendricks assumed the secretarial responsibilities of the association and Doctor Combs retained the treasurer-ship. Few, if any, other state medical associations had lay secretaries at that early period.

"During its first year of operation, 1924, the committee met every two weeks, or oftener if business demanded it. A report of work done reveals that 2,031 letters were written, forty-seven articles on medical topics were sent to 120 newspapers and ten periodicals, speakers were supplied for twenty-seven public meetings, a representative of the committee attended thirteen county and five district meetings—a big achievement for a baby department. Expenditures for the year were \$5,086.37.

"Down through the years the minutes of the meetings of the Committee on Publicity are replete with instances wherein it rose to defend the medical profession from attacks from the laity. Although it was not intended to be a 'Board of Censors' or a 'Committee on Medical Ethics,' there were times when the profession was criticized and its reputation damaged by acts of some of its members. The Committee on Publicity quickly condemned unethical practices brought to its attention in no uncertain terms, in reports submitted to the House of Delegates. The committee, under the chairmanship of Doctor Wishard, a stern disciplinarian, exerted a tremendous influence in purging the profession of unethical conduct which brought medicine into public disfavor. Physicians

were sometimes called before the committee to explain their actions.

"Upon the death of Doctor Wishard on January 23, 1941, Dr. A. M. Mitchell of Terre Haute, then president of the state medical association, appointed Dr. Homer G. Hamer of Indianapolis, as chairman of the Committee on Publicity. Doctor Hamer is now the committee chairman and has been continually since his appointment.

"Some of the rules of professional conduct established by the committee follow:

1. No physician in private practice should have his name mentioned over the radio. Names of physicians holding public office and connected with public institutions may be mentioned.

2. Advertising is unethical except as it conveys only information as to the doctor's name and location of his office and his office hours.

3. It is 'unethical, unwise and misleading' to permit scientific papers to be published in lay papers before their publication in medical journals.

4. The making of startling statements which produce scare headlines in newspapers belittles the profession and is disapproved.

5. Doing one's work well and interpreting it as impersonally as possible to the medical profession is the best way for a physician to extend his reputation.

"The duties of the Committee on Publicity as set forth in the By-Laws of the association:

'It shall be responsible for the dissemination of information concerning individual and community health to the lay public through articles prepared for publication in lay publications, or for addresses or talks delivered before any lay audiences under the authority of the association, and shall in every way seek to give the lay public a better knowledge and understanding of the aims and objects of scientific medicine.'

"The committee is composed of five members, three of whom are appointed by the president. The president of the association and the executive secretary are ex-officio members.

"The present Committee on Publicity meets every two weeks at state association headquarters. Articles on scientific subjects are prepared for submission to the press; radio programs, both transcribed and locally written, are sponsored weekly; speakers are supplied lay organizations and county medical societies, all in the finest traditions maintained by the committee during the past quarter of a century. It is unquestionably one of the most active committees of the state association.

"Members of the committee, all of them from Indianapolis except ex-officio, since it was established:

Wm. N. Wishard, Sr., Chairman, 1922-1940
 Frank W. Cregor, 1922-1924
 David Ross, 1922-1924
 S. E. Earp, 1925-1926
 Wm. A. Doeppers, 1925

Murray N. Hadley, 1926-1928
 John A. MacDonald, 1927-1929
 C. P. Emerson, 1929-1931
 Jas. H. Stygall, 1930-1935
 E. D. Clark, 1932-1935
 F. M. Gastineau, 1936-1942
 E. Vernon Hahn, 1936-1937
 C. F. Thompson, 1938-1940
 H. G. Hamer, Chairman, 1941-
 F. W. Taylor, 1941-1942
 Ben B. Moore, 1943-1947
 Karl R. Ruddell, 1943-1946
 David L. Smith, 1947
 J. O. Ritchey, 1948-
 Marlow W. Manion, 1948-"

CONSTITUTION AND BY-LAWS

These were revised in 1925 and the last recodification was in 1937. There have been a few changes since then. Omitted from the purposes of the Association were the words "foster the material interests," this to signify the purely scientific nature of the organization and avoid special taxes that might be due to profit making. Delegates now are eligible to hold any elective office. In the case of hyphenated county societies, each county in the group is entitled to one delegate. The number of mid-session Council meetings was increased from one to three. Transfer of membership, formerly automatic, must now be voted upon. Allowance has been made for the pro-rating of dues. A committee appointed in 1946 recommended no revision stating that "the general plan of organization of medicine in this state is in entire agreement with American principles of representative government and actually provides more 'home rule' than in our civil government." A new committee on revision is reporting in 1948.

As a peroration to this history, Tom Hendricks has written the following tribute entitled "Hoosier Centennial Punch."

"I've got it—I've got it at last," mused Aesculapius, God of Healing, as he peered down from the heights of Mount Olympus upon the hurried, harried, worried world of 1948. "That is," he explained, "I've discovered a perfect recipe for a state medical association. We will call it 'Hoosier Centennial Punch' in honor of the Indiana State Medical Association which is celebrating its one hundredth anniversary this year. Here it is:

"Take as base ingredients high professional attainment, sound scientific background and devoted service to the citizens of Indiana that have marked the Indiana profession for the past 100 years. Add the whole-hearted support of some 3,500 doctors who compose 100 active county and district medical societies that now make up the Indiana State Medical Association. Pour in three schooners of enthusiasm, hard work, good planning by officers, the Council, and score or more of functioning committees—blended together by a round-the-clock, on-the-job, headquarters office and journal staff. Season to taste with a dash of medical political bitters, and Indiana humor, even on special occasions adding a touch of Hoosier high hat hilarity, not

forgetting liberal portions of good fellowship. Shake or stir vigorously and serve in twelve attractive issues of the *Journal*, and at bang-up annual state meetings, numerous yearly functions and get togethers that put sparkle in the Indiana Association.

"Here, Gentlemen, is a sure fire recipe that has made the Indiana State Medical Association a leader among professional organizations of the nation, and when followed will guarantee life, vigor and vitality to other state societies.

"Though far from being the largest, the most scientific, the wealthiest, or the showiest state society, the Indiana State Medical Association is recognized for its leadership. The question naturally arises as to why it stands among the best, which poses the question of what makes any medical organization great:

First—Men who make it up.

Second—Facilities with which to work.

Third—Traditions.

Fourth—Spirit and Morale.

"Indiana is rich in all four of these essentials and the Indiana State Medical Association today has behind it a century of achievement which enables it to look forward—confident that this leadership will be maintained in the future.

"Consider the men who make up the Indiana State Medical Association; they are outstanding in their communities, in their state, and sometimes in the nation. Scarcely a year passes that some Indiana physician is not an officer in one of the national organizations. Several years ago at an Indiana State meeting four Indiana physicians were introduced as presidents of their respective national groups. It is significant that in its hundredth year the Indiana State Medical Association has seen one of its members, Dr. R. L. Sensenich of South Bend, become president of a national organization, the American Medical Association.

"But it isn't the men who become national officers that we think about when we speak of the 'great men who make up the Indiana State Medical Association.' We think of the hundreds of doctors who, without thought of recognition, take responsible positions in county medical societies.

"Scarcely a state has a functioning medical society which, in one way or another, does not owe something to Indiana. Here are some of the things which the Indiana State Society has pioneered in Indiana and has contributed to state and national organizations:

1. The Indiana State Medical Association was one of the first to have a full-time state society headquarters office.

2. Indiana was among the first to have records of every individual physician in the state, a file that was set up by Dr. Charles N. Combs when he was state secretary and the secretary's office was at Terre Haute. These basic files are still in use at the headquarters office.

3. The Indiana State Medical Association was one of the first to recognize the need of public relations, and created the Bureau of Publicity.

4. The method of legislative procedure with full functioning district and county committees adopted in Indiana from the Illinois Society has been followed by many other state societies.

5. The *Indiana Journal* was the first to use half-column cuts, to take commercial advertisements off the cover page, to have full page cover pictures, and was the first to use the picture of a living physician on its cover.

6. The *Indiana State Medical Journal* is known nationally for its editorial shorts.

7. The Indiana State Medical Association was the first to have a military preparedness committee, established several years before World War II.

8. Indiana was the first state society to have a state meeting combined with national groups, such as the U. S. Navy and the U. S. Air Corps.

"The State Medical Association, headed by a Council and an Executive Committee which meets monthly, is an organization that truly reflects democracy at work. But it isn't because of techniques and refinements in medical organization that the Indiana society is outstanding; it's because the Indiana State Medical Association has an individuality, a flavor, and character of its own.

"So, let's lift high our glasses and drink our Hoosier Centennial toast to that grand gentleman from Indiana—The Hoosier Doctor."

INDIANA'S PART IN THE A.M.A.

Presidents:

Theophilus T. Parvin, 1879.

James F. Hibberd, 1894.

R. L. Sensenich, 1948.

Vice Presidents:

James F. Hibberd, 1st vice president, 1865.

George F. Keiper, 4th vice president, 1916.

Wm. N. Wishard, 1st vice president, 1918.

F. B. Wynn, 1st vice president, 1922.

Judicial Council:

D. C. Peyton, 1902-06.

F. W. Cregor, 1923-33.

Jas. F. Hibberd, Secy., 1893.

Board of Trustees:

Jos. Eastman, 1894-1900.

M. F. Porter, 1900-09.

C. A. Daughtery, 1909-13.

R. L. Sensenich, 1937-47 (Chairman 1945-7).

Vice Speaker of the House of Delegates:

A. E. Bulson, 1933.

Standing Committees:

F. B. Wynn, Scientific Work, 1900.

J. N. Hurty, Public Health, 1913.

C. P. Emerson, Moving Picture Films, 1928.

F. S. Crockett, Legislative Activities, 1930.

F. S. Crockett, Rural Medical Service, Chairman, 1947-9.

Reference Committees:

Legislation and Public Relations

R. L. Sensenich, 1941, chairman 1936 and 1940. 1940.

H. G. Hamer, 1944.

Edwin Walker, 1914.

John N. Hurty, chairman 1911.

A. E. Bulson, 1918.

Reports of Officers

F. S. Crockett, chairman 1933.

H. G. Hamer, 1941.

A. E. Bulson, chairman 1929, 1927, 1917, 1925.

Constitution and By-Laws

R. L. Sensenich, 1934.

A. S. Giordano, 1947.

A. E. Bulson, 1920.

Edwin Walker, 1913.

G. F. Keiper, 1924-5.

Medical Education

F. S. Crockett, chairman 1937.

J. R. Eastman, 1924, chairman 1922. 1931-32.

A. S. Giordano, 1946.

Miles F. Porter, 1915.

Miscellaneous Business

F. S. Crockett, 1938, 1931.

Edwin Walker, 1910.

A. E. Bulson, 1916.

Executive Session

D. F. Cameron, 1938.

Credentials

Geo. Dillinger, 1939-40.

Hygiene and Public Health

D. F. Cameron, 1943 and 1946, chairman 1944.

W. N. Wishard, chairman 1910.

Rules and Order of Business

J. Rilus Eastman, 1919.

Industrial Health

H. G. Hamer, 1946.

Report of Trustees

H. G. Hamer, 1948.

A. E. Bulson, 1928.

General Medical Practice

H. G. Hamer, 1947.

F. S. Crockett, 1948.

Sections and Section Work

F. W. Cregor, chairman 1931-2.

David Ross, 1929.

A. E. Bulson, 1922, chairman 1923.

J. Rilus Eastman, 1915.

Rules and Order of Business

David Ross, chairman 1930.

A. C. Kimberlin, 1911.

Section Officers

F. B. Wynn, chairman Section on Pathology and Bacteriology 1902.

Chas. N. Combs, secretary Section on Anesthesia 1939.

R. C. Beeler, vice chairman, Section on Radiology 1940, chairman 1941.

R. J. Masters, secretary Section on Ophthalmology 1946-7.

C. H. McCaskey, vice chairman Section on Laryngology and Otorhinology 1947.

A. B. Graham, vice chairman Section on Gastro-enterology and Proctology 1928.

Frank Cregor, vice chairman Section on Dermatology and Syphilology 1923.

Editorial Board Archives of Otolaryngology
C. H. McCaskey, 1943-6.

Secretary Grass Roots Secretaries' Conference
A. M. Mitchell, 1947-9.

Director Scientific Exhibits
F. B. Wynn, 1899-1916.

The minutes of the first meeting of the House of Delegates of the American Medical Association in 1846 lists Dr. Azariah B. Shipman of LaPorte University as the one delegate from the state of Indiana, and judging from the record he was very active in his duties.

The first committee appointment on record was that of Doctor Daniel Meeker of LaPorte on the Committee on Medical Education in 1848.

House of Delegates:

G. W. H. Kemper, 1904-06.

Edwin Walker, 1904-15.

W. N. Wishard, 1904-10.

D. C. Peyton, 1904-07.

J. F. Barnhill, Delegate from Section on Laryngology and Otorhinology 1905 and 1920.

J. B. Berteling 1907-08.

A. M. Hayden 1908, Alternate 1915-18.

G. W. Thompson 1909.

H. C. Sharp 1909.

A. C. Kimberlin 1910-11.

C. H. McCully 1910-11.

John N. Hurty, Delegate from Section on Preventive Medicine, 1911.

M. F. Porter, 1911-12, 1915-18, Alternate 1913-14, 1919-20.

F. A. Tucker 1911-12, Alternate 1910.

J. Rilus Eastman 1912-17, 1919-26, Alternate 1910-11 (16 yrs.).

F. B. Wynn 1913-14.

C. S. Bond 1913-14.

C. H. Good 1915-18.

A. E. Bulson 1916-32 (17 yrs.).

Chas. Stoltz 1918-19.

Geo. Spohn 1920-21.

G. F. Kieper 1922-26.

David Ross 1926-31, Alternate 1925.

E. M. Shanklin 1927-29, 1938, Alternate 1926, 1935-37.

Harry Elliott, 1927-30, Alternate 1922-5.

F. W. Cregor, Delegate from Section on Dermatology 1929-34.

F. S. Crockett, 1930-49, Alternate 1926-30, (24 yrs.).

C. N. Combs 1931-32.

R. L. Sensenich 1932-37.

D. F. Cameron 1933-47 (15 yrs.).

H. G. Hamer 1933-48.

Geo. Dillinger 1939-45, Alternate 1938.

A. S. Giordano 1946-48, Alternate 1939-45.

Wm. N. Cockrum 1948-49.

Alternate Delegates:

J. T. Dikes 1908-9, R. L. Whitesides 1908, 1916-7, G. H. Grant 1909, Curtis Bland 1911-2, J. B. Garber 1911-2, G. R. Osborn 1912-5, W. R. Davidson 1912-3, T. E. Spink 1914-5, J. M. Dinnen 1913-4, C. F. White 1915-8, W. H. Stemm 1916-7, E. E. Evans 1918-9, H. B. Hill 1918-9, B. D. Myers 1920-1, C. D. Humes, 1920-1, E. R. Griswold 1922-3, M. R. Combs 1921-4, J. A. MacDonald 1924-5, B. G. Keeney 1926-9, Wm. Kennedy 1926-9, D. C. McClelland 1928-9, Robt. M. Moore 1929-32, W. C. McFadden 1930-2, G. D. Scott 1930-5, G. J. Geisler 1932-4, W. F. Carver 1933-5, Geo. Daniels 1936-7, W. F. Kelley 1933-40, N. M. Beatty 1938-49, A. M. Mitchell 1936-49, J. E. Ferrell 1941-4, Carl Ruddell 1945-8, Geo. Collett 1946, N. K. Forster 1947 and W. H. Howard 1948.

Secretary Council on Medical Service and Public Relations:

Thos. A. Hendricks 1945-

Indiana's initiative in creating the Scientific Exhibit is treated earlier in this history and all through the years Indiana doctors have participated in the scientific exhibits and in reading papers before the different sections. In 1948 the American Medical Association gave an award to the most outstanding general practitioner in the nation and Indiana's contestant, Dr. J. T. Oliphant of Farmersburg, was third out of a field of 180 entries.

Note: Acknowledgment is hereby made to Dr. Joseph H. Weinstein and Miss Lucille Kribs for assistance in editing the manuscript of this chapter.—C. N. C.

III

A CHARTER MEMBER AND HIS SON

WILLIAM HENRY WISHARD

January 17, 1816-December 9, 1913

WILLIAM NILES WISHARD

October 10, 1851-January 21, 1941

By

ELIZABETH M. WISHARD*

THERE was little that was inviting in the life of a doctor when the Indiana State Medical Society had its beginnings one hundred years ago. It was a hard grind for any young man who wished to attain the goal of a professional life. Educational opportunities did not go beyond the log school house with many, while the length of a school year was correspondingly short, limited to a few months of the winter when weather conditions prevented cultivation of the soil; nor did these schools offer any preliminary preparation for a scientific calling.

The limited circulation of currency and lack of traveling facilities made it impossible, except for a favored few, to attend the colleges, either academic or medical, that had been established in the eastern states.

My father, Dr. William Henry Wishard, had come from Kentucky as a lad of nine years in 1825, when his parents formed part of a small colony that settled on the western side of Johnson County, near the banks of White River. They did not wish to rear their children in a slave state and were glad to join the exodus of their neighbors who were like-minded.

As the eldest of eleven children, Father felt it was his duty to remain in the home of his parents until he had become of age, though he had long been cherishing the ambition for a wider field of activity than the limits of farm life in the forests of Johnson County then offered. He received little encouragement from those about him; even his father told him he would spoil a good farmer in the making of a poor doctor.

In Scotland there were those among his forebears who had attained positions of distinction in the professions, as well as service on the seas, and it may have been the stories of his ancestors to which he had listened that inspired in him the ambition to follow their example. It was then the order of the day with most of the medical students to study with preceptors, and later, if opportunity offered, attend a medical college.

Following the former plan Father entered the office of Dr. Benjamin S. Noble of Greenwood, Indiana, who was a brother of an early governor of Indiana, February 28th, 1838. Father was admitted as a member of Dr. Noble's family, thus

enhancing the intimacy he was to enjoy until Dr. Noble moved to Iowa.

In writing of those early student days under the direction of his instructor, he said, "When I began the study of medicine I did not have a luxurious library to work in, with its easy chairs, brilliant lights, and its walls lined with well filled book cases. I did most of my reading in the woods, and my studies did not include a very large number of books. They consisted of Thompson's *Practice of Medicine*, Chapman's *Therapeutics*, Chashaw's *Physiology*, Dewees *On Obstetrics and Diseases of Children*, Pancoast-Wistar's *Anatomy*, and a work on chemistry, all of which were my preceptor's books. I later purchased Eberle's *Practice*, his *Materia Medica* and his book on *Diseases of Children*."

The difficulties he encountered in securing a skeleton whereby he could better pursue his studies in anatomy, a venture which almost brought him within the grip of the law, are humorously described in his paper, "Medical Retrospect of Fifty Years," given at the fortieth anniversary of the Indiana State Medical Society.

It was not long until Dr. Noble began taking his student with him that he might observe his method of examination and diagnosis, when a long drive or horseback ride between patients would give ample time for the experienced doctor to explain to his student the symptoms of a patient and why certain remedies had been prescribed. After these clinical observations Father would turn to his text books for the instruction they offered. In critical cases his preceptor sometimes left him to care for patients until the crisis had passed.

After two years of study with Dr. Noble the latter offered Father a partnership when it was decided that the combined services of the two doctors could better serve an expanding territory if Father settled at The Bluffs, in Morgan County, ten miles southwest of Greenwood. The nearest physician south of Greenwood was at Franklin, ten miles away. An equal distance north to a physician was Indianapolis. Competition was no keen in those pioneer days.

It was not until 1845 that the way opened for Father to matriculate as a student of medicine in the Medical College of Ohio, located at Cincinnati, where he spent a full term. Professional and domestic duties prevented another absence from home

* Indianapolis. Author of *William Henry Wishard; a Doctor of the Old School* (1920).

until 1848, when he went to LaPorte, Indiana, where in 1842, the Medical College of Indiana had been established. It antedated by one year the launching of Rush Medical College and within the student body were some who later became prominent in the profession, among whom were Dr. Lomax of Marion and Dr. Baker of Stockwell. Dr. Everts, who served many years as Superintendent of the Central Hospital for the Insane at Indianapolis, received his training at LaPorte. It was at LaPorte Father came to know Dr. W. W. Mayo whose sons later established the Clinic at Rochester, Minnesota, that is world wide in fame. It was from the Medical College of Indiana, located at LaPorte, that Father received his first diploma, as a member of the class of 1849. He was privileged to return to Cincinnati for another course of lectures, as he always referred to his medical college experiences, and was awarded a diploma with the class of 1851. In later years the Medical College of Indiana granted him an honorary diploma in recognition of his long and faithful service in the profession of medicine.

In those earlier days a doctor was often deprived of the benefit of consultation with other doctors, thrown upon his own resources, and compelled to make his own decisions. An instance that illustrates this fact was given when Father was attending a young girl seriously ill with typhoid fever. It was an accepted theory then that water should be withheld from patients whose temperature was above normal. Being left alone one evening, while the family was at supper, the girl slipped out to the well, lowered the bucket and was satisfying her thirst to the fullest degree when discovered. She was hastily returned to bed and a messenger was sent with utmost speed for the doctor. When Father arrived he found the patient sleeping, her temperature lowered and so thoroughly relaxed and comfortable that he at once reversed his opinion and decided the "no water" theory was a mistake. From that turning point in her case the youthful patient was allowed all the water she thirsted for and in due time accomplished a complete recovery. The degree of temperature a patient might have been surmised as fever thermometers were then unknown.

Dr. A. W. Terhune, in his "Historical Sketch of Medicine and Medical Men in the Early Days of Johnson County," has vividly told how Father tactfully led a patient away from her established faith in goose grease as a potent remedy. "An amusing instance of the ignorance of the times in the use of domestic remedies was experienced by Dr. W. H. Wishard when a young man. One day he chanced to be in the country, calling upon a patient, when a neighbor woman came in with a small child which was comely and interesting with the exception that its head was a mass of festering ulcers, covered with the horrible incrustations of scald-head. Its hair was matted and disheveled and was still further befouled by a

liberal application of some oily substance that had been applied for curative purposes, but that was evidently utterly powerless to effect a cure. Dr. Wishard became interested in the poor afflicted creature and asked the mother what was the matter with her child. She informed him and he asked her what remedy she was using. She told him that she was using goose grease. She said that she had used it for quite awhile as it was the best remedy to be had for such diseases, but that it seemed to be of no avail in this case. The doctor looked very grave and said that perhaps the goose had not been killed in the right time of the moon. The woman said, with some little hesitation that she thought it had been killed at the proper time. The doctor then said, 'Are you sure it was a goose? Perhaps you killed a gander by mistake.' The woman, with a worried look upon her face, said she didn't know that made any difference. The doctor suggested that it might, at any rate that something had been lacking in the art of preparation of this oil so that it was entirely inert, that the case was very severe and other remedies would be required. The woman readily assented, and from that time on the child had the best of treatment."

Superstitious cures were not confined alone to the uneducated. The principal of a school I attended, a man highly educated, who obtained his training in his native land, Germany, acknowledged he always carried a buckeye in his pocket as a preventive of rheumatism. I heard him make the statement and was puzzled to see any connection between the disease and the prophylactic treatment he prescribed for himself. Asafetida bags were placed around children's necks to ward off disease. Poultices of almost unlimited variety were used for boils and felons to give relief and to "draw them to a head." Flaxseed, mustard, scraped beef and a variety of other remedies supplied the demands for relief such applications brought to a sore chest or aching back. Salves were also in demand for boils and carbuncles, and I have a vivid memory of a favorite prescription Father used in making a salve that required a whole day, with low heat, for dissolving and combining all the ingredients. Mother became quite an expert in preparing this particular remedy. It was a frequent sight to see an old-fashioned iron kettle on the cooking stove filled with hot water, with a gallon container inside the kettle in which the ingredients were slowly blended. This process was never carried out over a hot surface of the stove but always pushed to the rear lest too much heat might mar the desired combination. What a boon the present day double boiler would have been in the days of the homemade salves! Laudable pus was still a coveted result. There was no corner drug store in those days where pharmaceutical aids could be obtained, nor had antiseptics been dreamed of. Limited knowledge of remedial agencies was no greater than the lack of welfare work and public facilities

for the care of the blind, the deaf mutes and the mentally ill. The doctors, like the pastors, in the pioneer days were sometimes paid for their services by garden products, fruits, eggs and poultry.

In a paper entitled "Some Personal Army Experiences," prepared for a meeting of the Indianapolis Medical Society held January 9th, 1906, when the doctors who had rendered service in the Civil War gave reminiscences, Father told how he was summoned by Governor Oliver P. Morton to his office soon after the declaration of war. Indiana's great war governor offered him a commission as a regimental surgeon, though he was beyond the draft age, but his home and professional obligations at that time were so urgent that he felt he could not pledge himself for an indefinite prolonged absence. After giving his reasons for being unable to accept the commission offered to him by Governor Morton, Father expressed his willingness to render any emergency service at home or within the war zone. Accepting the offer Governor Morton asked him to go to Pittsburg Landing and remain during the siege of Corinth. He made no assignments but gave Father the liberty of going where his services seemed to be in greatest demand. A special duty became his in bringing home wounded Indiana soldiers and others incapacitated by illness for active duty. Among those he helped to return to their homes were some Indiana physicians and surgeons who had become physically unfit for service.

It was Father's privilege to witness an incident of historical significance. At that time he was in service with the Indiana Eighty-third regiment near Vicksburg. General Grant's headquarters were about one hundred and fifty feet from the hospital maintained by this regiment. Father chanced to be standing near General Grant's tent on that eventful morning, July 3, 1863, when an orderly in great haste arrived and delivered a message to a sentinel who disappeared. In a moment General Grant's voice was heard as he exclaimed, "And so they want to surrender, do they?" General Grant wrote a dispatch for the messenger to carry back to the Confederate headquarters and soon after mounted his horse, joined by his aid and orderly, and went to meet General Pemberton. About two o'clock the next morning all on duty, as well as the soldiers in camps and hospitals, were aroused by an orderly riding at high speed and blowing a trumpet as he hurried to headquarters, announcing in a loud voice the unconditional surrender of the Confederate Army.

In the early part of his army experience Father became acutely aware of the number of disabled northern soldiers who were sick or wounded, wholly unfit for duty, and that their recovery would be greatly enhanced if they could be returned to their homes, but the red tape orders of some of the army surgeons and physicians made it impossible for him to gain facts and statistics that would present a satisfactory report to Governor Morton.

Fortunately he gained the co-operation of Quartermaster General Stone who joined him in visiting the field hospitals where they obtained a complete report of the physical condition of disabled Indiana soldiers. Armed with this evidence Father and General Stone started for home, stopping at Milligan's Bend to get a report from the Van Buren Hospital. Upon their return they called upon Governor Morton who was so impressed by the need for giving immediate aid to Indiana soldiers that within a day or two he left for Washington where he presented the situation to Secretary of War Stanton who declined to offer any assistance. Governor Morton told Secretary Stanton that he would remain in Washington until he accomplished his desire, and if he failed the country at large would be told of the neglect. Governor Morton then sought an interview with President Lincoln who called a meeting of his cabinet where Governor Morton was asked to make a full statement. Surgeon-General Barnes was called into consultation and asked to confirm the report Father had tabulated or show where it was incorrect. General Barnes had brought with him reports that were on file in his office and upon comparison stated there was only a difference of three percent in the totals his office had gained and those given by Father. President Lincoln turned to Secretary Stanton and told him such conditions could not be tolerated in the army and directed him to issue an immediate order for the return to their home states of all disabled men. At once Governor Morton wired to those in authority in Indiana to see that a boat was equipped and sent south without delay. The Sunnyside, with Father in command, was the first boat to go from Indiana, specially commissioned, to bring to their homes soldiers who were unable for further war duty.

Previous to the Civil War my parents had moved to near Glenn's Valley and were living on the farm which Grandfather Wishard had acquired from the government when he came from Kentucky, Father having purchased it from his father. Desiring to give his children better educational opportunities, he decided to abandon farm responsibilities, which, added to his professional duties, proved somewhat burdensome. In 1864 he established himself in his profession at Southport where, for thirteen years, the family resided. When the time came for the professional interests of the sons to be a consideration, Indianapolis seemed the logical place for them to locate, but our parents had no thought of allowing a separation of residence to come about so early in the lives of their older children, who were then ready to launch out for themselves. While in a stage of indecision, the suggestion was made that Father announce himself as a candidate for the office of coroner of Marion County, to which he was elected in the campaign of 1876, and soon after the family moved to Indianapolis. By the time his reelection took place in 1880, he was established in the Hoosier capital.

It was Father's accurate memory that brought to light and helped to establish as a part of the permanent history of Indiana medicine the fact that Dr. John S. Bobbs of Indianapolis had done an original bit of surgery. One day he called at the office of Dr. Alembert W. Brayton, long time editor of the *Indiana Medical Journal*, when Dr. Brayton told him of an article in a well-known medical journal which related an important event in the history of surgery. The author described an operation which he had performed for removal of the gall bladder, claiming it was the first on record. Father replied that it was a mistake and said that in his address as president of the Indiana Medical Society in 1868, Dr. Bobbs gave a description of the operation which occurred June 15, 1867. Father added that he had seen and examined the stones; moreover that there were several physicians living who witnessed the operation. Suiting the action to the word, Father invited Dr. Brayton to go with him to his office where he had a complete file of the annual Transactions of the Indiana State Medical Society since its organization. In the copy for the meeting of 1868 appeared Dr. Bobbs' address in which he described the operation and which Dr. Brayton read with intense interest. So elated and delighted was he that he enjoined secrecy upon Father, explaining that in the next issue of the *Indiana Medical Journal* he would give the full history of the case, and added, "What a scoop it will be!" His prophecy came true and medical journals all over the world commented upon the case and credited Dr. Bobbs with having performed an original operation which he described as "A Case of Lithotomy of the Gall Bladder."

The annual report of the Indiana State Medical Society for 1869 tells of the first effort made to establish a state hospital in Indiana, when the following resolution was offered at that meeting by my father. "Whereas, The State of Indiana has no general hospital in which the unfortunate and poor of the state can receive medical and surgical treatment; Resolved that the President of this Society appoint a committee of one from each congressional district to memorialize the next General Assembly to make an appropriation to establish and support a hospital for the treatment of such persons." It was moved that the resolution be made the special order for ten o'clock the following day. When the question came up for general discussion at the appointed time a surprising opposition came to the front, while others made a strong appeal for action leading to the accomplishment of this greatly needed project. When asked as to his motive in suggesting the creation of such an institution, Father offered the following explanation and appeal: "My object in bringing this subject before the convention is not only to ameliorate the sufferings of the unfortunate and indigent poor, but to save to the profession many cases of surpassing value. I know of a number of surgical cases which, on account of the want

of facilities furnished for treating them at the county poor houses, have failed of cure and been lost to the world and to the profession. There are many physicians who know how totally inadequate are the appliances and comforts afforded at the county asylums. If the many cases that have fallen under my observation—cases that with proper treatment might have been cured—had been brought to a hospital, the facts elicited would have furnished the most valuable material for our medical journal, and the success attending the treatment would have redounded to the glory of the profession. We now have no general hospital for the state. Other states have such institutions, and I think it time we were having one. We need some place for giving attention to cases requiring the most scientific practice in surgery. I have now in mind a surgical case of great importance. The person had no means and was taken to the county asylum. There no appliances are furnished the physician for giving proper attention to the case, the consequence of which will be that a cure cannot be effected. Besides, the cases under proper treatment would have furnished valuable data to the profession and would doubtless have been cured. It is with these views that I introduce the resolution."

The discussion which followed resulted in the president, Dr. John S. Bobbs, appointing a committee representing each congressional district with Dr. Bobbs as chairman. The report Dr. Bobbs gave at the following convention, 1869, stated that the response had not been as cordial as he had hoped for; that some did not seem to comprehend the underlying purposes. Dr. Bobbs fully committed himself to the effort and introduced a resolution favoring the erection of a hospital at Indianapolis. Father seconded its adoption, which was unanimously accepted as a memorial to the Legislature. Before another annual meeting of the Society was held Dr. Bobbs had died. If he had lived, this first effort in the direction of the establishment of a hospital for Indiana might have become a reality. As Father was then serving by appointment as physician to the poor of Perry Township, he was keenly aware of the need of a hospital such as he longed for. Organized effort was new and doubtless did not appeal to many, particularly the doctors who were far removed and did not quickly grasp the benefits to be derived.

Dr. W. R. King stated it well at the Fortieth Anniversary of the State Society when in discussion he said, "I want to say one thing to the young men belonging to this Society, and that is, we owe a great debt of gratitude to the gray hairs who are members of this Society; we can scarcely realize the difficulties under which the older members practiced medicine years ago."

In retrospect their early efforts may seem very crude but life in all its aspects in the middle west was then in the making. It required courageous spirits to forge ahead, inadequately equipped as

they were, but they opened an ever widening trail along which others have followed.

In the days of Father's active professional life the family doctor was the obstetrician. He commented upon the fact that he had never rendered such service when twins were added to a family. However, after he had passed his eighty-seventh birthday he was called to care for an obstetrical case when triplets joined the family. For several years Father followed the history of the babies as they developed into normal children.

As I listened to my father's recital of the desires which prompted him to study medicine, I felt he believed he was divinely called to his profession as many ministers believe they are called to the pulpit. His ethical standards were always high. As long as his strength permitted he was a regular attendant upon the meetings of the State Society. He was privileged to attend the opening session of the meeting held in 1911 in Indianapolis after he had passed his ninety-sixth birthday, when his devoted friend, the president, Dr. Frederic C. Heath, invited him to the platform and without any warning, called upon him to extend a greeting to the delegates. His approach to all professional questions dulled slowly as the years advanced, and when unable longer to attend any meetings he wanted to have read to him all available reports. His earthly pilgrimage ended thirty-nine days before he would have reached his ninety-eighth birthday.

Father's faith in and ambition for medical organizations were firm and enduring, and could, perhaps, be expressed in no more forcible language than he used in the closing words of his address as president of the State Society, when he said, "The Indiana State Medical Society has been a power for good in our profession, especially since it has been a delegate body. It has stimulated the organization of local societies and elevated the professional standards so high that physicians who have the opportunity to join medical societies and do not avail themselves of it, will find themselves in the rear ranks, and sooner or later be assigned to the invalid corps, fit for light duty only."

The medical map had been greatly changed by the time my brother, Dr. William Niles Wishard, decided he wanted to follow in the professional footsteps of his father. He was born while our parents were living in Greenwood and was reared in a medical atmosphere, so it was a natural sequence that he should cherish such a desire, and that in early life his tendencies pointed toward a career in medicine.

Will took his preparatory training in the High School at Southport, after spending a year in a private school in Tecumseh, Mich., and then became a student in Wabash College where his anticipated course was suddenly ended by a serious illness which sent him home not long before he finished

his second year. To aid in his restoration to health Father had his son join him on long drives, when quite naturally the conversation drifted toward medical subjects, and Father found himself repeating the experiences he had with his preceptor, he assuming the role of instructor with his son as the student. When the summer ended Will was fully restored to health but had undergone a change of desire. Instead of returning to college he was so eagerly inclined toward beginning the study of medicine that our parents yielded to his entreaties and he became a student in the Indiana Medical College, graduating with the class of 1874. The course then required only two years. Following his graduation Will practiced with Father a year at Southport and then went to Cincinnati, Ohio, where he took a post graduate course at the Miami Medical College, now a department of the University of Cincinnati, and was awarded a second medical diploma in 1876.

While serving as deputy coroner my brother performed many autopsies as well as engaging in private practice until he was elected Superintendent of the Indianapolis City Hospital in June, 1879, where he remained until January, 1886. He was succeeded in that position by his close friend of many years, Dr. John H. Oliver, who had served as intern while Will was Superintendent and later became one of the most eminent surgeons in Indiana.

At that time the City Hospital was poorly equipped, lighted by kerosene lamps and heated by stoves that would burn soft coal only. The first night after Will assumed his duties the lamp which hung from the ceiling in the main hall of the building where the doctors lived exploded. Fortunately serious damage was averted. It was not long until gas was installed for lighting, followed soon by a heating plant. A large bell similar to those used on farms to call the field workers to meals hung out of doors at the side of the front hall and each doctor, or anyone serving officially, had a special call. Naturally, the call of the Superintendent was one stroke. The rope that manipulated the bell hung inside of the entrance hall window. The hospital was located in a negro section, with few white people in evidence. It was commonly reported that the negroes living nearest who heard the bell told others that when it rang it was the signal to give the patients quinine. It was not strange that such a fancy gained the confidence of those who believed the story for the swamps that were then in evidence were fertile breeding beds for malaria and mosquitoes.

Dr. Livingston Dunlap, the first president of the State Society, was the moving spirit in the erection of the first city hospital for Indianapolis, 1854, when there was a population of only 5,000, though the hospital never really functioned until it was turned over to the government during the Civil War.

I will quote from an article my brother wrote in which he gave some facts regarding the history

of the Hospital. "A brick building, intended as an Indianapolis city hospital, had been erected through the vision and efforts of the late Dr. Livingston Dunlap before the Civil War but had not been used. The government took charge of it during the war and added some frame cantonments which were utilized in connection with the old building. In June, 1865, at the close of the Civil War, the Indiana Soldiers' Home was created and the Indianapolis City Hospital building was utilized from July, 1865, until April, 1866, with the late Dr. Milton M. Wishard as superintendent, which position he held after its removal to Knightstown and until his death in 1877. During the Civil War the State of Indiana cooperated with the federal government in the management of the hospital and the late Dr. John M. Kitchen was the chief medical officer with Dr. Milton M. Wishard as resident. On July 1, 1866, the city occupied the building as a city hospital for the first time with the late Dr. Greene V. Woollen as superintendent. When the hospital was taken over by the city it was supposed to have a capacity of seventy-five beds, but the actual capacity was not more than fifty or sixty beds. The office of superintendent was for one year and Dr. Woollen was superintendent until July 1, 1870, by annual reappointment. The City Hospital has been in continuous existence ever since, but the old building and the frame structure added during the war were wholly inadequate and poorly suited for hospital use until the erection of the new City Hospital during the writer's superintendency from 1879 to 1887. The new buildings were commenced in 1882 and were completed in 1884 and 1885. They had a capacity for 125 patients and were regarded as thoroughly modern and up-to-date at that time. The east wing was completed during the spring and summer of 1883 and immediately occupied. On September 1st of that year a Training School for Nurses was opened, probably the second training school for nurses established west of the Alleghenies and the first in Indiana. The second wing, built in 1884, and the third in 1885, constituted what was then known as the new City Hospital. While still used by the city they are entirely overshadowed by the splendid new buildings that have been erected in recent years, but they served adequately their purpose for many years and constituted the first modern general hospital erected in Indiana and were greatly appreciated by the medical profession and the public."

With the cooperation of the Flower Mission, Will was enabled to establish the Training School for Nurses as a part of the hospital. This was the second training school for nurses west of the Alleghenies. The Flower Mission was organized to add cheer and comfort to the poor, whom members visited in their homes and hospitals, distributing flowers and dainty articles of food.

The first superintendent of the School was Miss A. A. Traver, an early graduate of the Training School for Nurses of Bellevue Hospital, New York.

After two years of service Miss Traver was succeeded by Miss Abby Hunt, a graduate of the same school. Miss Hunt was a very popular superintendent and established the school upon a firm foundation. She retired from duty the same day my brother did and soon became the bride of Mr. Peter F. Bryce, long time president of the City Hospital Board. In later years Mrs. Bryce was the active promoter in the organization of the Visiting Nurses Association of Indianapolis, which has spread to other cities in Indiana. Always lovingly referred to as "Mother Bryce" she will ever live in the hearts of those who remember her.

Opposition was aroused during the organization of the Training School, when one well-known physician in the state voiced his disapproval by remarking, "Doctor Wishard, why in the world are you trying to establish a training school for nurses? Don't you know if you give the nurses a course of lectures and reading on medical subjects they will presently get so wise that they will presume on their knowledge and interfere with your prerogatives as a physician?" Will replied to him, as he did to others who were antagonistic to the effort, that he believed in time the school would justify its existence. When convinced of its merits the objecting doctor became a warm-hearted advocate.

In the annual report submitted to the City Council by the superintendent for the year ending May 31, 1881, it was stated that 550 patients had been admitted during the year just ended. Meat purchased at wholesale prices cost \$1,016.55 while \$2,939.17 had been spent for groceries, including fruit, and \$118.59 for ice. These supplies not only provided food for the patients but served the table for the staff as well as the employees.

When my brother assumed his duties as superintendent his salary was \$50.00 per month, afterwards increased to \$75.00, including all living expenses. There was no staff of visiting physicians when Will assumed his duties, each of the hospital doctors being free to call any one he desired when in need of consultation, but it was not long until a well organized staff was appointed, representative of the best talent the profession afforded. A trying situation came to the front when a doctor representing one of the irregular schools of medicine was elected a member of the City Council and sought membership on the Hospital Board. His first effort was to create a visiting staff representative of all schools of medicine and it was no easy task to overcome his determined and well laid plan. Fortified by the Hospital Visiting Staff and other members of the profession, as well as far-seeing members of the City Council, this unethical endeavor failed.

It was during my brother's incumbency at the hospital that antiseptics came into use and were demonstrated at the hospital for the first time in Indianapolis by Dr. John Chambers, a brilliant Britisher, who brought great ability to his chosen

field as well as honor to his adopted city. So successful was this innovation in surgery that it was immediately accepted by the profession at large. During his term of office Will centered his energies largely on the erection of modern buildings and equipment. The difficulties he encountered were hard to overcome and today would be considered culpable. As an entering wedge he petitioned for an appropriation of \$6,000.00 for one building which was eventually raised to \$60,000.00.

Upon his retirement from the hospital a group of professional friends honored my brother by giving a testimonial dinner at the Denison Hotel which stood for years as a landmark at the corner of North Pennsylvania and Ohio Streets. Prominent physicians responded to toasts, among them Dr. John M. Dunlap, the first nose and throat specialist in Indianapolis and son of the founder of the City Hospital. Dr. J. L. Thompson presided as toastmaster. Dr. Dunlap spoke upon the subject, "The Old City Hospital—Dunlap's Folly," while Dr. Thomas B. Harvey responded to "The New City Hospital—Wishard's Wisdom." Others spoke upon topics assigned them, the last one being Dr. John Chambers who, on behalf of the assembled friends, presented the guest of honor with a microscope, a timely and much valued gift. As the New Year bells rang out the old year and welcomed 1887 the guests stood and sang "Should Auld Acquaintance be Forgot."

In the brief report of the event which Dr. Brayton gave in the *Indianapolis Medical Journal* several years later he made note of the clergymen who were present, with special reference to the Reverend R. V. Hunter, D. D., then our family pastor, commenting upon Dr. Hunter's physical and mental vigor, as well as his spirit of eternal youthfulness. In his tribute to his parishioner Dr. Hunter said in part, "Dr. Wishard should have been a lawyer for he has great legal ability and forcefulness. Indeed in his hospital work we may say 'he socked it to Socrates, ripped up Euripides, scissored Cicero, raised Caesar by the seat of his breeches and raised hell on the Hellespont.'" The last clause of this quotation had a significance that was easily fathomed by those of the inner circle.

An intern whose ambition exceeded his better judgment, influenced as he doubtless was by others who wished medical recognition, brought charges of inefficiency against the hospital superintendent, who immediately went before the City Council and asked for an investigation. Public meetings were held by the Hospital Board which resulted in complete vindication for the accused. No doubt the intern eventually wished he had not placed himself in such a tangle when some witnesses testified he told them he expected to be appointed superintendent when Dr. Wishard was discharged. He failed to sense the metal of the man he had to face in trial, nor did he take into account that he would have his name stricken from the roll of members of the Indianapolis Medical Society.

After his retirement from the hospital Will went to New York for post graduate work, with special reference to urology, which was then almost an unknown branch of the healing art. He not only attended lectures but became a private student under Dr. F. R. Sturgis and Dr. Eugene Fuller. While at the City Hospital he performed autopsies that convinced him surgery would have saved the lives of some patients, all of which increased his desire to become a genito-urinary surgeon.

When he established an office in his home city the time did not seem ripe to limit his work to the special line for which he had been fitting himself, but after a year he withdrew from general practice and became the first specialist in his chosen field in his native state. Not only Father but some medical friends were doubtful of his decision.

My brother sought to keep in touch with the more than sixty-five doctors who had served with him as hospital interns, office associates or students for whom he was ever solicitous for their welfare and professional advancement.

In recognition of the fortieth anniversary of his graduation in medicine Will gave a dinner, February 28, 1914, to which all of these old friends were invited, repeating this social function ten years later. Some traveled a long distance to be present at these reunions.

In token of fifty years of faithfulness to the interests of his profession the Indianapolis Medical Society made Will the guest of honor at a banquet held in the Riley Room of the Claypool Hotel, June 13, 1924, when his portrait, painted by Steele, was unveiled by Dr. David Ross. It now hangs in the library of the Indiana University School of Medicine beside one of his father painted by the same artist. Dr. William Lowe Bryan, then president of Indiana University, graced the occasion in the capacity of toastmaster.

When my brother reached the sixtieth anniversary of his professional career the senior class of the Indiana University School of Medicine honored him with a banquet held at the Riley Hospital.

Will held membership in numerous medical organizations, the first being the Marion County Medical Society of which he became a member in 1875, one year after his graduation. The same year he identified himself with the State Society which elected him as president in 1897, presiding as he did at the meeting held at Lafayette, 1898. He served as president of the Indianapolis Surgical Society in 1890, and of the Mississippi Valley Medical Association in 1895. Both of these organizations ceased to function long ago. He was elected second president of the American Urological Association in 1905, and was a member of the House of Delegates of the American Medical Association from 1902 until 1913, and was chosen first vice-president of the Association in 1919. He was an active member of the American Association of Genito-Urinary Surgeons for many years and made an honorary member in his later years. When he

retired as president of the Indiana Board of Health in 1911 he had been a member since 1900.

My brother never held any professional position that brought to him greater satisfaction or pleasure than his chairmanship of the Bureau of Publicity, an adjunct of the State Society, which he occupied from its organization until the end of his days, covering a period of nineteen years. He was an honorary member of the Association Francaise D'Urologie.

In 1883 he was appointed assistant to the chair of Medicine in what was then the Medical College of Indiana, but in 1887 when the department of Genito-Urinary Surgery was established he was made a full professor and placed at the head of that division, a position he held for forty-nine years. He was active in the enactment of medical laws, being the author of the Medical Practice Act in Indiana which stands today practically as written and passed by the State Legislature in 1897 and which has eliminated the irregulars in medicine, which at that time were known as eclectics, homeopaths or other titles, whose training, or lack

of it, fell far short of the preparation every practitioner in medicine should have.

Honorary degrees were conferred upon Will, the first an M.A. coming from Wabash College in 1890. Others followed when in 1919 Wooster College, Wooster, Ohio, honored him with an LL.D., as did Indiana University in 1924. In 1928 DePauw University conferred an Sc.D., as did Hanover College in 1933.

At one time the *Indiana Medical Journal* noted the fact that covering a period of forty years my brother rendered continuous service on committees or some special commission for the State Society.

While Will prized the many opportunities that came his way to serve as a physician and officer in organizations other than medical, the public tie that was nearest his heart was that of elder in the church of his fathers, a position he held for forty-two years, Father having served in the same office for sixty-eight years.

In faith and doctrine they were of one accord as they were in service to their fellowmen.

IV

THE JOURNAL

Part One

E. M. SHANKLIN, M.D.*

THE official organ of the Indiana State Medical Association is in its forty-second year, though the Association is readying for the celebration of its centenary anniversary.

From 1849 to 1907 there was annually issued a volume known as the *Transactions of the Indiana State Medical Society* [Association after 1903], one copy of which was sent to every member. For some years past we have had much pleasure in dropping in at headquarters, picking up an old volume, say fifty, sixty or seventy years old, running over the list of papers presented and scanning the membership rolls, presented by counties as they were in those days.

Some fifty years ago there was some agitation for a state medical journal. At first the proposal did not meet with a hearty response, but in due time it was conceded that we should have our own official magazine. We recall that at a Council meeting this matter was fully discussed. One of the old-timers declared, "We are big enough—certainly old enough—to have a journal of our own." At that time there were several medical journals established in the state, a list of which will be found in another article. The deterrent factor was, of course, the cost of getting out a new publication. It meant a new system in our organization, the naming of an editor and his staff and arrangement of many details.

After a year or two of discussion Dr. Albert E.

Bulson, Jr., of Fort Wayne, who had for some years been editor and publisher of the *Fort Wayne Medical Journal*, made a proposal to the Council, which finally was accepted. He proposed to publish an official monthly journal, from his Fort Wayne office, the Association to pay him seventy-five cents per year, per member. Doctor Bulson was to have full charge, looking after all advertising, *et cetera*, and whatever profit might accrue would go to him.

The Council took the matter under consideration and at a later meeting entered into a verbal contract with Doctor Bulson on the above basis. During the twenty-five years Doctor Bulson published the *Journal* there was no written contract, and though the per capita arrangement was "upped" on two or three occasions, no other changes were made in the arrangement.

In later years there was some criticism because of the fact that in his annual report to the Council Doctor Bulson made no reference to the financial phases of the program. On two or three occasions this fact was discussed in the Council and some effort made to get some data on the subject; however, this suggestion reached no more than the discussion period, and not until early in 1933 did the Council members have any definite knowledge of *Journal* finances.

One of the high lights of the earlier days of the magazine should be mentioned, that of the connection of Miss Hope Toman, of Fort Wayne, with our *Journal*. She entered into employment by Doc-

*Hammond. Editor Emeritus.

tor Bulson directly upon leaving high school and remained with him until his death. We recall an incident she relates: that soon after she went into the office Doctor Bulson indicated that he planned soon to take her on as his personal secretary and install her in the library, where the magazine "office" was located. This arrangement was made. After two or three weeks of it she remarked to Doctor Bulson, "I do not fit here and I think I will do better back in the general office." He voted this down and Miss Toman was an established fixture.

Doctor Bulson died July 17, 1932, and the Council appointed a committee to go to Fort Wayne and look over matters. It happens that the writer was a member of the committee, and he recalls several incidents of that trip. As we have said, Doctor Bulson was *THE Journal*; in fact, he commonly referred to it as *MY Journal*—and his it was.

The Indiana State Medical Association owned nothing in that office, not even a typewriter. One member of the committee very bluntly began to ask questions of Miss Toman, wanting to know who owned this, and who owned that. He was told that Doctor Bulson owned the whole outfit.

On that same trip a local doctor contacted a member of our committee, stating that he wanted to buy the magazine, but did not know whom to approach about it.

The Council was deliberate about their action, taking plenty of time to go into all details. Numerous names were proposed for the position of editor. Some members made an active campaign for the job.

At the September meeting of the Association, held in Michigan City, Dr. E. M. Shanklin, of Hammond, was named to the post. The Council was fully advised that the nominee had had no editorial experience, save in a local society capacity, and he was hesitant about giving an immediate answer. Finally he accepted with two reservations: that the magazine should be published in Indianapolis, and that Miss Toman be imported to that city, there to remain until things began functioning.

Such is a rather brief story of our official organ, now in its forty-second year and a healthy, lusty "infant." We use that term because there are so many official organs in the country far older than ours.

Part Two

RAY E. SMITH*

DURING the century that the Indiana State Medical Association has been in existence, its history has been recorded officially in two publications. The first of these, the *Transactions of the Indiana State Medical Society*, was issued annually for fifty-eight years by the Committee on Publication of the Association. The *Transactions* covered all scientific and organization work, and copies were mailed to each member. As far as is known, only one complete set of the *Transactions* is available today—at the Indianapolis Public Library. Beginning in January, 1908, the *Transactions* was succeeded by a monthly periodical, *The Journal of the Indiana State Medical Association*, issued by authority of the Council of the Association.

Entering into the twentieth century with a membership of more than sixteen hundred, the thriving medical organization became impatient with the once-a-year *Transactions* and a demand for a publication more in keeping with the times asserted itself. At the Winona Lake meeting of the Association, in 1906, a communication from the Ninth Councilor District recommended that a state medical journal be established. The Committee on Publication was directed to investigate the feasibility of such action. It made a survey of the county medical societies and found overwhelming sentiment in favor of a monthly journal. The Council,

on October 15, 1907, voted to establish a medical periodical. The problem of finances, however, seemed insurmountable, but Dr. Albert E. Bulson, of Fort Wayne, who had edited the *Fort Wayne Medical Magazine* for fourteen years and was a member of the Council, rather than see the proposal abandoned, offered to assume the editorship and to accept the financial responsibility. Doctor Bulson took on the financial gamble, and in return for mailing a copy to each member, the Council agreed to pay him seventy-five cents out of each member's annual dues. Doctor Bulson lost money on the *Journal* at first, but kept his agreement. In later years, as the volume of advertising increased, the *Journal* became a profitable publication.

A man of seemingly boundless energy, courageous and outspoken, Doctor Bulson announced in the lead editorial in Volume I, Number I, January 15, 1908, that the *Journal* would be as large and as good as finances and his capabilities would permit. At the risk of great personal financial loss, Doctor Bulson declared in the editorial that "the advertising pages will at all times be free from nostrum advertisements." He never deviated from the policy.

Doctor Bulson edited and published the *Journal* at Fort Wayne for almost twenty-five years, until his death on July 17, 1932. Meantime, as costs increased, the apportionment of dues for the *Jour-*

* Indianapolis. Managing Editor.

nal advanced to \$1.00; subsequently to \$1.50 and, in January, 1921, to \$2.00 a year. Now it is \$3.00. Under Doctor Bulson, the *Journal* stuck doggedly to high standards and ethical ideals, even when it meant loss of revenue and, maybe, friendships. Its scientific articles, progressive editorials and accurate reporting, coupled with its refusal to accept quack advertisements, soon elevated the *Indiana Journal* to a place of high esteem in the medical publication field. Doctor Bulson did an excellent job. The *Journal* was his hobby,—a part of his life.

Dr. Miles F. Porter, Sr., of Fort Wayne, became acting editor upon Doctor Bulson's death, but the greatest share of responsibility fell upon the shoulders of Hope Toman, who had been up to that time an efficient assistant to Doctor Bulson for more than eleven years. Meantime, a special committee of the Council was appointed to decide upon the *Journal's* future. It recommended to the Council at a special meeting August 4, 1932, that the Association take over the *Journal*, that the office be moved to Indianapolis, and that Miss Toman be engaged as assistant to the editor, that the executive secretary of the Association become the managing editor and business manager, that an Editorial Board of five members be selected, and that a new editor be appointed.

The recommendations of the committee were carried out, and at a meeting of the Council at the time of the annual session in Michigan City in September, 1932, Dr. E. M. Shanklin of Hammond was elected editor. Drs. Charles N. Combs of Terre Haute, Ernest Rupel of Indianapolis, and Pierce MacKenzie of Evansville, were elected to the Editorial Board. Mr. Thomas A. Hendricks, executive secretary at the time, was directed to find state headquarters' space large enough to accommodate the *Journal*.

Before he died, Doctor Bulson was making plans for a Silver Anniversary Edition in December, 1932, commemorating the twenty-fifth anniversary of the *Journal*. As some of the articles were already in preparation, Doctor Porter and Miss Toman proceeded with the special issue. It was, in fact, however, more of a memorial to Doctor Bulson, with nine pages of tributes to the late editor, and feature articles by the late Dr. William Niles Wishard, Sr., Dr. J. H. Weinstein, Dr. B. D. Myers and Dr. William F. King.

The *Journal* entered into its second quarter century in January, 1933, under entirely new circumstances, with the exception that Miss Toman remained with the organization. The editorial office was located at 1021 Hume Mansur Building, Indianapolis, and the printing was done in Indianapolis instead of Fort Wayne. Doctor Shanklin, the Editorial Board, and Mr. Hendricks, the managing editor, all had a deep feeling of responsibility as they assumed their new assignments. The new editor, in his first editorial, gave this pledge:

"In our advertising columns we will admit only 'accepted' articles, and it goes without saying that

mention of the non-accepted variety in scientific articles will be taboo. We shall most earnestly, not to say valiantly, oppose anything that smacks of state medicine; we shall attack any form of commercialism in medicine and we will uphold the ethics and traditions of the profession as we have observed them in more than thirty years in the service."

Miss Toman remained with the *Journal* until 1941 when she resigned to marry Dr. Joseph Skobba, then located in North Vernon, Indiana. In her more than twenty years in the *Journal* office, she contributed immensely to its development and its success.

The *Journal* is the official mouthpiece of Indiana medicine, its editorial and financial management are directed by the Council-selected editor, the Council-selected Editorial Board and the Council-selected managing editor and business manager.

Now in its forty-second year, *The Journal of the Indiana State Medical Association* is a member of the Cooperative Medical Advertising Bureau of the American Medical Association, which procures the national advertising accounts for it. Its advertising space is open only to concerns whose products are pronounced reputable by the various councils and bureaus of the American Medical Association.

The *Journal* is carrying on today in the rich tradition of its birth, fulfilling the heritage of high idealism left it by Doctor Bulson. It is acknowledged as "one of the best" among state medical journals, a position it hopes to uphold until the end of time.

EDITORIAL BOARD MEMBERS

1933-1949

M. A. Austin, Anderson: 1944-1946
 Herman M. Baker, Evansville: 1942-1943
 James F. Balch, Indianapolis: 1940-1942
 E. L. Bulson, Fort Wayne: 1946-1948
 Raymond F. Carmody, Gary: 1949
 F. R. N. Carter, South Bend: 1946-1948
 E. L. Cartwright, Fort Wayne: 1949
 Charles N. Combs, Terre Haute: 1933-1934, 1945-1947
 Bert Ellis, Indianapolis, 1945-1947
 Harry W. Garton, Fort Wayne: 1943-1945
 L. P. Harshman, Fort Wayne: 1935-1938
 Robert V. Hoffman, South Bend: 1942-1944
 Edgar F. Kiser, Indianapolis: 1939-1941
 Kenneth G. Kohlstaedt, Indianapolis: 1948-1949
 Pierce Mackenzie, Evansville: 1933-1941, 1947-1949
 J. B. Maple, Sullivan: 1939-1941
 Minor Miller, Evansville: 1944-1946
 L. G. Montgomery, Muncie: 1942-1943, 1947-1949
 Jacob T. Oliphant, Farmersburg: 1948-1949
 Lyman T. Rawles, Fort Wayne: 1939-1941
 T. B. Rice, Indianapolis: 1933-1939
 James O. Ritchey, Indianapolis: 1942-1944
 F. T. Romberger, Lafayette: 1933-1939
 Ernest Rupel, Indianapolis: 1933-1938, 1943-1945
 E. L. Van Buskirk, Lafayette: 1940-1942

V

HISTORY OF THE INDIANA STATE BOARD OF HEALTH

THURMAN B. RICE, M.D.*

One hears it said that the pioneers who settled in Indiana were a hardy and healthy stock which could withstand any hardship and was highly immune to disease. Such is very far from being a true statement of the facts, we assure you. There was a vast amount of sickness in those days and the specter of death was constantly at the doorstep. The forests and swamps of Indiana held other enemies far more deadly than the Indians of whom we have heard so much. During the summer months malaria—called “the chills and fever” or the “ague”—was a veritable plague, particularly in the swampy northern sections of the State. Nearly every person had an enlarged spleen (known as “ager cake”) in his side as a result of malarial infection, and “Is this your chill day?” became a familiar form of salutation. Typhoid fever, dysentery, cholera infantum and even Asiatic cholera were extremely prevalent during the summer months. In the winter respiratory infections of all sorts, scarlet fever, diphtheria, pneumonia, and a great many other related diseases were all too common. Many of these and other infections were never diagnosed; others were given a colloquial name which means little today. Smallpox and “consumption” took heavy toll at all seasons. It was not very uncommon for a whole neighborhood or town to be rendered desolate or depopulated in a single season.

The first known reference to any health work in Indiana seems to be an editorial in the *Western Sun*, Vincennes, Indiana, August 20, 1808. It urged that the people of that pioneer town improve the public health by cleaning out the decaying grass in the river opposite. The same paper on September 3 of the same year, compares the streets of that town to an Indian camp and is very uncomplimentary, saying that it is not uncommon to see carcasses of horses, dogs, hogs, etc., lying in the streets. In March, 1819, this same town passed what was probably the first health ordinance in the State, but it is believed to have been very poorly enforced because the people did not see the need of such precautions. On August 6, 1824, Madison passed a somewhat similar ordinance designed to keep the streets free of rubbish and garbage. On July 10, 1832, a more specific health ordinance was passed in the hope that the Asiatic cholera which was spreading rapidly might be checked in that city.

Probably the first state recognition of the public health was a proclamation of Governor Noble who, on October 18, 1832, set aside the second Monday in November as a day “for fasting and prayer to

an over ruling providence, beseeching Him to arrest the progress of the disease with its train of calamities, and in behalf of the churches he bespeaks the aid and influence of all who believe in the efficacy of prayer.”

There was a board of health in Bloomington as early as August, 1833. Madison attempted to pass such an ordinance in 1834, but the attempt failed. The first board of health in Fort Wayne was established in 1842. The first health board in Indianapolis was established in 1850. A historian, telling of this event adds: “There was so much ill feeling among the members that they did no good until 1854, when Dr. Jamison became a member and managed to put the concern in working order.”

It will be recalled that in June, 1849, a momentous medical convention was held in Indianapolis and at that time the Indiana State Medical Society was organized. On that occasion a resolution was unanimously adopted and reads as follows: “Resolved that a committee of five be appointed to memorialize the Legislature, asking them to provide by law for registration of births, marriages and deaths.” It was just at this time that cholera was raging in various parts of the State. As a matter of fact, one of the delegates to the convention was unable to come because of cholera. This was Dr. W. H. Dowling of New Albany. There is little doubt that the scare from the cholera was the thing that activated the interest of the medical profession at that time. Even such a disaster as an epidemic of Asiatic cholera then can be used to advantage.

A year later in May, 1850, the State Medical Society met again and passed the following resolution: “Resolved that a committee of five be appointed in distant parts of the State, whose duty it shall be to report to the executive committee at least once a month before the next annual meeting, all meteorological facts and their connection with epidemics. Resolved that the executive committee be instructed to frame from the facts a report which may be of general interest.”

At a meeting of the State Medical Society of 1851 it was “resolved that as the responsibilities of the medical profession as conservators of the public health require at their hands all proper effects to protect the community from the injurious effects of nostrums and patent medicines whose composition and constituent elements are unknown and often unfit to be used; and whereas this growing evil which is impairing the health and wasting the means of the community can be reached and remedied in no way so well as by legislative enactment; therefore a committee of seven shall be appointed whose duty it shall be to prepare and present to the Legislature a memorial setting forth

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concisely the evil and dangerous results of the vending and use as medicines, preparations whose constituent parts are unknown, and requesting at their hands such enactment as may compel under penal sanctions all vendors of secret remedies to append to them a full and true detail of their compound elements." It was nearly a half century before such a law was actually passed, and much longer before it was enforced.

The first effort of any consequence to secure for Indiana a state law covering the matter of public health and vital statistics was made by the State Medical Society in 1855. The leader in this movement was Dr. William Lomax of Marion. The attempt failed because the Legislature was little interested in matters pertaining to health and tremendously concerned with problems which seemed at the time more important, particularly state banking laws.

After this attempt failed there is little record of further efforts in this direction until 1873, when Dr. Sutton of Aurora, presented a report before the Indiana Medical Association on "Diseases of Indiana for the year 1872." He said, "At the meeting in the spring of 1870 it was suggested that some plan should be adopted by which we might have the annual report of facts, showing the health or sickness in the different counties, the prevailing diseases, the season of the year in which different forms of disease most frequently prevail, etc." To procure such information committees were appointed at that time in each congressional district who were to report to the Society at its next annual meeting. This plan after being tried two years in succession, not succeeding as well as desired, a committee was appointed at the last meeting, that is 1872, to collect facts and report to the chairman who was to condense and embody the information received into one report to be presented to its meeting in 1873.

In the report of 1874 Dr. Washburn of Logansport, in an article entitled, "Medical Legislation," speaks of the necessity for the State collecting accurate vital statistics and urged that a proper registration law be enacted.

At this point we must digress from the record temporarily and tell something of a remarkable character who now appears on the scene in Indiana, and who is responsible for nearly all of the basic work in public health done previous to the time of Dr. John Hurty. This individual was Dr. Thaddeus M. Stevens of Indianapolis, born in 1829. Dr. Stevens was the nephew of Thaddeus Stevens, the congressman from Lancaster, Pennsylvania, who was such a thorn in the side of Presidents Lincoln and Johnson, and who played a sinister part in the reconstruction era after the Civil War. The two names are often confused and we therefore made the point of bringing out the relationship. It is said that in the early 1870's Dr. Stevens was accustomed to appear before his class at the Medical School and say, "Gentlemen, it is all very well for

us to diagnose and treat typhoid fever and other such diseases. It would however, be infinitely better if we could prevent them." This was strange doctrine in those days and called forth considerable comment and not a little scorn. We find that in 1875 Dr. Stevens read a paper before the State Medical Association entitled, "State Board of Health." He said, "We hope this Society will not adjourn without appointing a committee whose duty it shall be to advocate this step and bring it before the profession and the people." The following year we find the president's address, Dr. Helm of Peru, was wholly devoted to advocating the passage of a health law establishing a state board of health and registration. In 1877 Dr. Hervey of Indianapolis, read an exhaustive paper entitled, "How to Secure Medical Legislation." He therein eloquently urged the passage of a state health law. In 1878 Dr. Luther D. Waterman, the president, devoted his official address to the subject of state medicine. He said in part, "In this State no enactments to protect the people from unnecessary diseases and epidemics have been passed." He denounced this condition as a disgrace to the State and urged the Association to stronger effort in the matter of health legislation. Dr. Waterman exhaustively reviewed the economics of health control, estimating the value of a human life unnecessarily lost at \$1,000. In the program of 1879, Dr. Thaddeus Stevens read a paper entitled, "Report of Public Hygiene in Indiana." In this paper Dr. Stevens ably set forth an argument in favor of supervision of the public health by the State.

From this time on we find a rather large number of papers devoted to matters such as the organization of a state board of health. It is interesting in the present connection to have us reminded that as a rule all of these matters came up for discussion under the title, "State Medicine." Obviously the term was used in an entirely different connection than it is used today. It was constantly applied to medical education and to public health control, and made no reference whatever to the thing which we now so much fear. When a speaker referred to "state medicine" he simply meant that the State should make itself interested in and responsible for the care of the insane, the preservation of health, registration of births and deaths, the licensing of physicians, medical education and all such measures as might be favorable to good medical procedure.

Dr. Thaddeus Stevens was the leader in most of this enterprise. In 1875, at his suggestion, a commission was appointed by the State Medical Society for the purpose of studying the problem and making recommendations looking toward the creation of a state board of health. Inasmuch as Dr. Stevens had made the motion for the creation of such a commission, he was made chairman. The other members were Drs. J. W. Harvey, James S. Athon of Indianapolis and Dr. George W. Burton of Mitchell. In 1876 Dr. Hobbs was appointed to fill the vacancy caused by the death of Dr. Athon. In 1878 the commission was given the title of

Indiana State Health Commission and several laymen were added to it, namely Lemuel Moss, D.D., president of Indiana University; John S. Campbell of Wabash College, and E. T. Cox, state geologist, of Indianapolis. Somewhat later Professor Cox moved from the State and Professor Collet, Chief of the Bureau of Statistics, was elected to fill the vacancy. About this time President Moss resigned and S. H. Charlton succeeded him.

The first meeting of this Indiana State Health Commission was held at the Grand Hotel at Indianapolis, October, 1878, and organized by electing the following officers: Wilson Hobbs, M.D., president; Thaddeus M. Stevens, M.D., secretary; George W. Burton, M.D., treasurer; J. L. Campbell, L.L.D., civil engineer. The Commission met again in December, 1879, and arranged a plan whereby the State was divided into local or district health commissions. These commissions were composed of the chairman of the whole district and a member from each county medical society. The duties of these district commissions consisted in collecting sanitary and vital statistics in their localities and reporting the same to the secretary of the State Health Commission who was, of course, Dr. Stevens. It will be understood that the Commission had little or no power to execute health ordinances, being only a branch of the State Medical Association, and it is doubtful if their vital statistics, selected and reported to the secretary of the Health Commission, were of much value. The Commission put out under date of 1880, a little booklet giving such vital statistics as they had been able to collect. It makes very interesting reading, indeed, but should not be regarded as a really accurate record of those times. It was only a beginning.

It soon became apparent however, that this was a much bigger job than had been supposed. We find therefore, that at the legislative meeting in 1881 a bill was introduced by Senator Flavius Josephus Van Vorhis. It was Senate Bill No. 93. The career of Senator Van Vorhis is one that is of much interest in the present. He had been a successful physician, and as a matter of fact, one of the best known physicians in Indiana, but decided that he didn't care to continue the practice of medicine because he couldn't very well lose sleep, so he changed his entire career when he was of middle age, read law for a few weeks, and set up as a lawyer. In time he was elected to the Senate and of course was very much interested in medical matters because he was also a physician. It is to him that we give credit for the writing of the bill which later became the basic health law. It is most interesting to us now to know that while he was in the Senate and contemplating this legislation he lived next to a young druggist who was already very much interested in the entire matter of health law and enforcement. It is said that Van Vorhis used frequently to sit on his front porch and discuss with this young man the project before the Legislature. The young man in question

was none other than John N. Hurty, who later was to become so prominent in the health field in Indiana.

On March 7, 1881, which was the last day of the session, the bill was passed by the house and signed by Governor Albert G. Porter. *The Indianapolis News* of the following day has the following comment on the bill:

"Two instances of loose legislation are found in the Board of Health Bill and the July Bill . . . We need not only more careful legislation in the framework, but we need more conservative legislation, more matured and more well considered legislation." It must be obvious from this that everything was not smooth sailing for the new bill. As a matter of fact, nothing at all was done toward putting the law into practice until November 3 of that year, at which time Governor Porter called the first Board of Health into session. Members were John W. Compton, M.D., Evansville; W. W. Vinnege, M.D., Lafayette; J. M. Partridge, M.D., South Bend, and Thaddeus M. Stevens, M.D., Indianapolis. (When later the seal of the Indiana State Board of Health was designed, this date, November 3, 1881, was used on the seal as the beginning of the Indiana State Board of Health). At this meeting Dr. Compton was elected president and Thaddeus Stevens was made secretary. The Governor then appointed William Lomax, M.D., of Marion, to fill the vacancy created by the election of Dr. Stevens to the secretaryship.

The first regular meeting of the Board was held January 19, 1882, and this date marks the real beginning of the State Board of Health as a functioning body. The total appropriation was \$5,000 a year. The inventory of the Board at the time Dr. Stevens took office was as follows:

"Three desks, two chairs, one filing case, one bookcase, eleven walnut chairs, two office chairs, gas fixtures, one wash bowl and pitcher, one postoffice scales, four cuspidors, carpets for three rooms, one clock."

Diligent search has been made to find where the offices of the State Board of Health were located at that time. We know that they did not meet in the State House but in a rented room somewhere outside. There is some reason to believe it was in a building which stood at the southeast corner of Capitol and Market streets where the Harrison Hotel now stands.

It might have been expected that Thaddeus Stevens, having been the originator of the Board of Health, would have been a good administrator. Such was not the case. Trouble began very promptly. Dr. Stevens was criticized for the disorderly way in which he kept the office and for the poor penmanship used in writing the minutes. As a matter of fact, the minutes as they are preserved in the record book are barely legible, having been written in his own scrawly hand. Criticism from all sides began to pour in and he was forced out

of office on March 15, 1883. One cannot say that he resigned because he refused to give up the office and there was a tremendous struggle as to the best means of getting him out.

As one reads the story of the life of Thad Stevens he is first filled with great admiration, and then as he reads on there arises a feeling of dismay and pity. He created in the State Board of Health a Frankenstein monster which turned upon its creator and destroyed him. Whatever may have been his faults however—and he had faults—he was a great and good man and much more interested in the “under dog” than in his own personal welfare—a theorist and a dreamer. He was born decades before his time and spent his life, his strength and his private fortune pushing against the great inert mass of ignorance and interference which in those times covered the state and the nation in matters pertaining to sanitation and the public health. It is true that he did not get the health program moving as rapidly as he wished, but he certainly did point the way.

Stevens' activity covered medical literature as an editor and author. He was greatly interested in medical and health education as a teacher in a medical college, and as one hoping to arrange for better teaching clinics than were then available. He was the first to propose what has become the great medical center of Indianapolis; he was the leader among those who sought to get a good law of medical registration and licensure; he was the first to provide a good clinical, toxicological and pharmaceutical laboratory in the State; he was early interested in the legal aspects of medicine, a very important phase of the subject in these times; he was early interested in the proper and sympathetic care of the insane; he strongly advocated the use of bovine virus for smallpox vaccination as opposed to “arm-to-arm humanized vaccine.” He made the first sanitary survey of the State of Indiana and of the City of Indianapolis; he was the leader in the movement for pure water and for the disposal of filth in such a way as not to pollute the streams and the ground water. He was one of the first medical historians in the State; he early advocated the collection of vital statistics and set up the first system for collecting the same in Indiana. He was not only the father of the State Board of Health, but also the origin of practically all of the health thinking and legislation of the time. He was the first secretary of the State Board of Health. Every one of the stones which he prepared and saw rejected, is now securely placed in the great organization which today guards the public health.

After Stevens was deposed the next secretary was Emanuel R. Hawn, M.D. Dr. Hawn was a politician and had been secretary of State. At the expiration of his term as secretary of State in 1883 he was made secretary of the State Board of Health but served only a short time as he died August 14 of the same year. He was ill during the

entire time of his administration and so was able to accomplish nothing. Dr. Hawn was an extremely large man. It was said that even after being ill for months, at the time of his death he weighed 360 pounds or thereabouts.

After the death of Dr. Hawn the appointment was given to Elijah S. Elder, M.D., who had been both president and secretary of the Indianapolis Board of Health. Dr. Elder was a capable man and much beloved. He later was dean of the Medical College of Indiana, and may properly be regarded as the father of the State Board of Medical Registration, though that Board was created some three years after Dr. Elder's death.

There is an interesting story in connection with his death. He was very ill when the State Medical meeting of 1894 was in session at Fort Wayne. It was known that he could live but a few hours and so the date for the election of the incoming president was set forward by one day and he was chosen president of the Indiana State Medical Association and immediately notified so that the notification would reach him while he was still alive. He died twelve hours after being notified of his election to the presidency of the Indiana State Medical Association.

In spite of the fact that Dr. Elder was probably the best qualified man who could have been found in 1883 for the position of secretary of the Indiana State Board of Health and was a very conscientious public servant, he was deposed for political reasons in 1885. Up to that time the Board had been solidly Republican but now the Democrats came into control of the Board and Elder was discharged after a dramatic struggle. His successor was Charles Metcalf of Indianapolis, who served from 1885 to 1896. Dr. Metcalf was a genial individual much liked by his associates and gave promise of being a useful man in the position. The big event of his administration was the passage of the amended health law on February 19, 1891. This law in general was very similar to that of 1881, but did make some minor changes which may be regarded as being advantageous. Toward the latter part of his administration he deteriorated seriously and became addicted to the use of alcohol to such a degree that he was almost completely incompetent. His wife was his secretary, those two being the only employees of the State Board of Health at that time,—the budget for the Board of Health was \$4,000 a year. It soon became evident that he was of no use to the State, his only official functions being the collection of vital statistics by very antiquated methods, and the occasional inspection of the State institutions, with the result that they were invariably described as being in excellent condition, though we now know that such could not have been the case. When efforts were made to depose him in 1895, it was found that there were two Democrats and two Republicans on the Board, each group being absolutely adamant in its adherence to political lines.

The two Republicans would vote for their candidate, the two Democrats for another, and Metcalf would vote for himself as he was legally entitled to do. This of course made it impossible to elect. In such case the incumbent would serve until a successor was elected. At each quarterly meeting the attempt was made to elect a successor, but each time it failed until the meeting of March 5, 1896.

Now comes a dynamic event in connection with the groundwork laid for this meeting. As a druggist Dr. J. N. Hurty came to work each morning to his drug store and laboratory at the corner of Ohio and Pennsylvania streets where the Federal Building now stands, he rode a bicycle past a row of buildings belonging to the Hon. William English, Sr. There was so much typhoid in this row of buildings that it had come to be known as "typhoid row." Dr. Hurty had his own ideas as to what caused this typhoid so he purchased a five-gallon can of kerosene and under cover of nightfall, went along this row putting about half a gallon of kerosene into each of the privies. The next day the water in the wells of the neighborhood tasted so strongly of kerosene that it could not be drunk. This was a spectacular demonstration as to the probable cause of the typhoid fever, but it didn't make any great hit with William English, who was extremely angry about it. Inasmuch as he (Mr. English) was a political rival of Governor Claude Matthews, the latter was greatly pleased by the Hurty demonstration and he made inquiry as to who this man Dr. Hurty might be. Somewhat later Dr. William Niles Wishard of recent memory, appeared before Governor Matthews and urged that Dr. Hurty be elected to the secretaryship of the State Board of Health. Hurty and Wishard were Republicans but Matthews was so disturbed by the inefficiency in the Board of Health that he gave his approval. He could not however, make the appointment inasmuch as that had to be done by vote of the Board itself. He gave his approval however, to the plan whereby Dr. Douglas C. Ramsey, a Democrat, from Mount Vernon, Indiana, would vote for Hurty, who was a Republican. As a result of this arrangement Dr. Hurty, on March 5, 1896, received three of the five votes electing him to secretaryship of the State Board of Health. He was authorized to take office on May 1, 1896. Dr. Metcalf was of course much disappointed and enraged by this arrangement, and it is said that he angrily left the meeting to imbibe strongly of alcoholic drinks. The story is that as a result he was exposed to the weather on that night and that he took pneumonia. Certainly it is the truth that he died five days later, March 10, 1896.

This unexpected event made it necessary that Dr. Hurty take over the secretaryship of the Indiana State Board of Health with only seven days' preparation for it, March 12, 1896. The appropriation at that time was \$4,000 a year, he had

no secretary inasmuch as the previous secretary, Dr. Metcalf's wife, refused to give any assistance whatever. It may be said then that Dr. Hurty started absolutely at scratch as secretary of the Indiana State Board of Health, March 12, 1896. The fact that he brought the State to a high development in this regard must be mentioned to his honor as he had very little help in this direction.

We do wish in this place also to give credit to Dr. William Niles Wishard who always supported him in every good thing that he attempted, and who was a practical planner and strategist in relation to the Legislature and the State Board of Health. Great credit too, must be given to Dr. R. Henry Davis of Richmond who, for twenty years, was on the State Board of Health and a very valiant fighter for health. Mention may well be given to Governor Marshall who did much toward improving the status of the State Board of Health, and to Dr. William F. King who in 1910, became Dr. Hurty's assistant and who succeeded him in office in 1922. A great many other persons might be mentioned as having served valiantly in helping Dr. Hurty, but these four persons stand in the front ranks.

It is impossible to do credit to the memory of Dr. Hurty in a few pages. An exhaustive biography has been written by this author and is readily available in the better libraries of the State. It is entitled, "The Hoosier Health Officer, A Biography of Dr. J. N. Hurty and A History of the Indiana State Board of Health to 1925." It is unnecessary in this place then to go into great detail concerning his administration, but we do feel that we should make a brief summary to indicate its nature and scope.

When Dr. Hurty came into office there was a great epidemic of typhoid fever raging in the State of Indiana. That epidemic may be said to have been a continuation of the one which caused him to come to the notice of the Governor. High incidence of typhoid fever was considered at the time to be essentially a normal condition of the State during the late summer and early fall months. It must be borne in mind that the germ concept of disease was not at all well understood in those days; there were no approved water supplies and indeed most of the water came from shallow wells. Flies hovered over the landscape in great numbers and constituted a serious health menace. Very few cities had any adequate method of sewage disposal; horses, cows, chickens and hogs were kept in the backyards of the citizens in even rather large cities. During the winter months certain infectious diseases of children took a heavy death toll; in particular we mention diphtheria, scarlet fever, measles and other such diseases as are now almost entirely eradicated, or at least are well handled so as to prevent death and disability. Tuberculosis took great numbers of people at all seasons of the year. Rather soon after he took office and just at the end of the Spanish American

War a tremendous epidemic of smallpox hit the State and continued to be a serious menace to health for several years. The venereal diseases were mentioned only in hushed tones and nothing whatever was done about them. Methods of diagnosis and treatment in those times were quite inadequate for the venereal diseases. A large percentage of babies died within a year of birth and many mothers died of childbed fever, it being supposed in those days that there was nothing whatever that could be done to prevent these conditions. They were simply dispensations of Providence. The long, long fight against these preventable diseases is still going on to be sure, but the problem is much less now than it was then.

When Dr. Hurty was running the drugstore at the corner of Ohio and Pennsylvania streets he was exceedingly conscientious and careful about the quality of his products. Those who knew his personal life will remember that he was exceedingly "touchy" on the subject of being cheated or of having inferior products sold to him. Early in his administration he began to give thought to means whereby he could insure for the people of Indiana not merely a more healthful food supply, but also one which would be really what it was supposed to be when the purchaser handed over good money for it. He began to ponder the possibility that there might be passed some sort of a law which would require that food be sold in an unadulterated condition. He succeeded in the spring of 1899 in getting a law passed by the Indiana State Legislature which contained a comprehensive definition of what constitutes "adulteration" of foods. This was one of the first laws of its kind to be passed in the world, and it is entirely possible that it was the very first. It is written in essentially the same language as the Pure Food Law passed June 30, 1906, the law which was sponsored by Dr. Harvey Wiley, who was also a native of Indiana. It is interesting however, to note that this bill was passed more than seven years before the federal law. The Indiana law of 1899 was held to be a great success though it was soon discovered that there was no way to enforce it for the very simple reason that the funds of the State were not adequate to prosecute violators in any considerable number of cases. Furthermore, there were no funds for the provision of a laboratory where food analyses could be made to determine whether or not standards had been met. Then followed a period of years in which Dr. Hurty struggled valiantly to get an appropriation for such a food laboratory. At session after session of the Legislature he failed, but finally in 1905 he succeeded in getting a small sum appropriated for that purpose. Such was the beginning of the Indiana State Board of Health laboratories. Indiana at that time was one of the foremost states of the Union in all matters pertaining to health and food legislation.

In 1899 Hurty became much interested in the matter of stream pollution, a subject which was

by no means understood by the public. He was sharply opposed by the manufacturing industries because it was said that the privilege of discharging waste matter into a river was an innate property right even if it did contaminate the river. Hurty was one of the very few men in Indiana who understood *why* sewage and industrial waste contaminate water by using up the oxygen, making it impossible for plants and animals to live in the water. He undertook to have laws passed and did partially succeed. In 1903 a stream pollution law was passed but it contained a joker which rendered it ineffective and put the burden of proof upon the State Board of Health at the time when that organization had no laboratories whatever to use in testing the water. Laboratory work was done in the private laboratories of Dr. Hurty in the room adjoining the drug store which he still owned, but for this work he received little, if any, pay. He could do very little such work because he had the other duties of his office to perform. He was undoubtedly one of the leaders in the whole matter of stream pollution. He continued this fight for years and during the period 1912-1914 actually had two houseboat laboratories on the rivers of the State. These boats would take samples of the water at close intervals, analyze them and make records. It was this relation as director of the laboratory boats on the river that caused Hurty to be dubbed "The Admiral of the Indiana Navy," a title which he much enjoyed and about which there was a great deal of newspaper publicity, both favorable and derisive. How silly this expenditure seemed to those who considered him a "crank"!

During the administration of Governor Durbin, Dr. Hurty was in constant trouble with the Statehouse. Durbin was opposed to the whole scheme for controlling stream pollution, and tried hard to have Hurty discharged from the Board of Health. He did not succeed in this, but as a matter of actual fact, caused Dr. Hurty to gain in the public esteem. He did however, frighten Hurty to the extent that he was willing and eager to accept a position as superintendent of health exhibits at the St. Louis Exposition which was held in 1904. Hurty made one or two trips a week to St. Louis for over a year and received a great deal of attention for the excellent exhibit that he prepared at that time. It is interesting to know in this connection that the State Board of Health received one and Dr. Hurty received another bronze medal from that Exposition. While on the subject of such awards we mention the fact that in 1900 he received the silver award for excellence of the Indiana State Board of Health at the Paris International Exposition, Paris, France. In 1907 he received a gold medal from the Jamestown Exposition. It will be seen from these facts that he was considered a very forward health officer in those times.

In the Legislature of 1905 and again in 1907 he was very much interested in social and moral re-

form. Governor Hanley was in the Statehouse at that time and was likewise much interested. Hanley was extremely bitter in his attacks upon the liquor and cigarette trade. He was also favorable to methods recommended by Hurty for the improvement of the marriage relation, and as a result the Indiana Marriage Law was passed under his administration. It required that the applicants testify that they were free from mental disease and the like. This law looks well on paper but has probably been of little real use. In the Legislature of 1907 Dr. Hurty helped sponsor a bill for eugenical sterilization. This law was passed but was not well accepted and as a matter of fact, was declared unconstitutional in Governor Goodrich's administration some ten years later. It was never well enforced. The principle of course has been established long since and with a better written bill, Indiana now is in the procession with some thirty-five other states having such a law. We were definitely the first in the entire world to have such legislation.

In the period 1910-1915 Dr. Hurty became much interested in housing and got a great many improvements made. The Indiana Housing Law was considered a model at the time it was passed. His associate in all this work was Mrs. Albion Fellows Bacon of Evansville. It was during this period also that great improvements were made in Indiana school houses. Dr. Hurty had gone about over the State in every nook and corner condemning school houses; after 1910 Dr. King had pushed this program. The work was extremely unpopular in the State but seriously needed to be done and did result in major improvements. In large measure the superior quality of the school buildings of Indiana should be given as credit to these two men. We are sorry to report that neither of them has been honored by having a school building named after him. We feel sure that such an honor has been richly deserved.

From the very beginning of his services as State Health Commissioner Hurty took an extremely active part in the work of the State and Territorial Health Officers' Organization and served at different times as an important official in that group. In 1912 he was elected president of the American Public Health Association which was a high honor indeed, and one which he was extremely pleased to accept. When the time came that he was to prepare his presidential address he made a considerable study of the State of Indiana in rural districts and wrote an exceedingly strong paper on the subject of rural sanitation. In that paper he made the dramatic statement "the American farmer stinks." This statement had hardly been made until it was rushed into print and sent all over the United States. The result was that farm people everywhere, and particularly in Indiana, were made very indignant. A strong effort was made to depose Dr. Hurty, and many of his speaking engagements were cancelled. He retaliated by citing in-

stances and calling further attention to the fact that rural sanitation was by no means what it should be. City sanitation left much to be desired in those days as now, and in all probability the rural districts were not far behind the cities in that respect. There was need that attention be called to the facts in the case. The episode caused him a great deal of embarrassment and resentment against him hung on for many years.

In 1915 a strong effort was made to depose him. The Legislature was offered a bill which would have taken all power away from him and would have compelled his resignation. He fought it however, and was victorious. At the time that the victory was definitely in hand a banquet was hastily called to honor the nineteenth anniversary of his election to the secretaryship. This banquet was one of the most distinguished gatherings that Indiana has ever seen. Vice-President Marshall and Senator Kern came all the way from Washington to be present; Governor Ralston presided. The presidents of Indiana and Purdue Universities were at the front table, as were also the presidents of the American Medical, the American Dental and the American Public Health Associations. On this happy occasion Dr. Hurty was given a beautiful vase with a picture of Huxley on it; inasmuch as he was a great admirer of Huxley this vase became his most treasured possession. It is still to be seen in the auditorium of the State Board of Health which is known as "Hurty Hall."

With the coming of World War I the work of the health officer was greatly increased. A tremendous effort was made to control venereal disease. The whole matter of food supplies was of the utmost importance. The Board of Health was at the same time weakened by loss of personnel to the armed forces. It was a strenuous period considering the fact that Dr. Hurty at this time was getting along in his sixties and was not very well. The great epidemic of influenza in 1918 was a great shock to him because he had been preaching that all diseases of a germ nature can be prevented by hygienic means. Then came along the disastrous epidemic—one of the worst in all history—and medical science was at a complete loss either to prevent or to cure this disease. He had always claimed that fresh air and good food with a reasonable amount of sleep, would insure health. Alas for his theory, it would do nothing of the sort in the presence of such an enemy as influenza.

About this time he became interested in the work of the Public Health Nurse and was an ardent advocate of all such work as she might be expected to do. He was also impressed with the great need of full time health officers and tried in Legislature after Legislature to get such a bill passed. As a matter of fact such a bill was passed, only after considerable effort, ten years after his death. It is a well demonstrated principle and one which now has the approval of medical men everywhere, but one which has not been popular in Indiana. He was bit-

terly disappointed on the occasion of the Legislature of 1921 and resolved that before another Legislature should come up he would run for office himself. Being on the floor of the House he felt it would be possible for him to carry the bill through. He announced his candidacy in the spring of 1922 and was the top man in the Republican primary. Then, being assured of the nomination, he resigned as secretary and State Health Commissioner to take effect September 30, 1922. When election time came he found himself the leader of the ticket and expected to do great things in the Legislature. We recall that at that time he was greatly excited and very, very optimistic. When the Legislature met they honored him by giving him a seat in the front row of the House, though he was not entitled to such a location on grounds of seniority. When appointments were handed out however, he was given poor committee appointments. It is true he was on the Public Health Committee but was in such a position that he had no great influence. The various things that he had proposed were gleefully voted down and so toward the middle of the term, greatly disappointed, utterly despondent, and suffering from the effects of an attack of "flu," he had to give up the work and spent the last two or three weeks of the term in his home. He was a badly disillusioned and embittered man. He lived until the latter part of March, 1925, but never regained his old fire. He had served a total of twenty-six and one-half years as secretary of the Indiana State Board of Health, and had become the dean of health officers in the United States.

If one had asked him what was his proudest accomplishment as Health Officer, he probably would have said that he was most gratified by his success in having Indiana adopt in 1899 a system of death registration and later in 1917 a satisfactory system of birth registration. How right he was could be dramatically shown at the time of World War II when hundreds of requests per day were made for birth certificates.

Another thing he did and of which he was very proud, was to begin publishing in April, 1897, the *Bulletin of the Indiana State Board of Health*. For something over two years this continued on a quarterly basis and then October 1, 1899, was started as a monthly publication. It has continued to this day and is the oldest state board of health bulletin to be continuously published. Beyond much doubt it is the largest, best illustrated and the most pretentious of all publications of its sort. It has had but three editors—Hurty, Dr. William F. King and the author of this historical sketch.

In addition to the outstanding work he did as secretary of the Indiana State Board of Health, he must be given credit for forty-four years of teaching at the Dental College and for about forty years at the Medical School. His was a most distinguished record. It has no equal for service in Indiana.

The next person to serve as secretary of the Indiana State Board of Health was Dr. William F. King who had been Dr. Hurty's assistant since 1910. He became secretary of the Board and State Health Commissioner October 1, 1922, and served until April, 1933. During the first part of his administration and all of the Hurty administration, the central office of the Indiana State Board of Health had been on the second floor of the State House in the room at the extreme northeast corner of the building. By the second floor we mean the floor on which the public enters the building and passes to the rotunda. In 1927 arrangements were made to transfer the State Board of Health offices to the State House Annex which is the old Medical School Building at the corner of Senate and Market. The offices and laboratories of the Board were then grouped in a compact unit for the first time and occupied the first two floors of that building. It seemed a good arrangement. During the King administration there was great development of the Public Health Nurse idea; of the principle that the State Board of Health should interest itself in the preservation of the life and health of mothers and infants; much interest in school hygiene; and a great development of the laboratory of the State Board of Health as it takes part in various diagnostic procedures.

It was during this administration that the Sheppard-Towner Act at the federal level was in force. This was the beginning of Federal participation in health and medical affairs and was not popular with organized medicine. Dr. Ada Schweitzer, who had been with the laboratory of the State Board of Health previous to the passage of the Sheppard-Towner Act was put in charge of the Division of Infant and Child Hygiene. Dr. Schweitzer was extremely energetic and conscientious. She was very active indeed and went about over the State setting up child clinics and baby shows; she prepared exhibits with posters and received much publicity calling attention to the fact that the health of children was not what it should be. There is no doubt whatever that she was honest and capable, but her methods were such as to arouse the antagonism of the medical profession and as a result she was not at all popular with them. At the same time the laboratory of the State Board of Health was being greatly enlarged in a diagnostic way and it was felt by the directors of many private laboratories that it was encroaching upon the prerogatives of those laboratories. All of these activities caused Dr. King's administration to be placed in jeopardy. We shall not at this time go into the merits of the case because the issue has long since been dropped and need not be recalled. There is no doubt whatever that Dr. King was a conscientious servant of the public and that he served the State well under rather trying conditions. It might be said that he did not consult the medical profession as much as he should have done and that his administration was for that reason widely misunderstood. In all

charity we must admit that it was a very difficult time. In the first place there was great distrust of the State administration during Governor McCray's administration and that of Governor Branch which followed; he (King) also served during the time in which the Ku Klux Klan had entirely too much to say in State government, and finally following the financial crisis of October, '29, we had the beginnings of the great depression with its terribly disturbing effects. Furthermore, during the latter part of Dr. King's administration the political situation in the State caused the State Board of Health to be split along political lines with the result that there was a great deal of sniping between the two political contingents which did nothing to improve the situation.

The political upheaval of November, 1932, produced a very profound change in the national and state picture. Paul V. McNutt, dean of the School of Law at Indiana University, was elected Governor. Governor McNutt was an ardent Democrat and tremendously ambitious, with his eyes already upon the White House. Enormous numbers of people were out of employment as a result of the depression now more than three years old, and the pressure for political jobs was tremendous. When Governor McNutt took office in January, 1933, he found himself in absolute command of the Legislature inasmuch as nearly all of the members were of his political faith. He needed only to express the slightest wish and it would be put into law without any further thought at all being given to the matter.

He felt that there was great need for reorganization of the State government. There were over a hundred boards of various sorts which were responsible to the Governor. These boards were dismissed in many instances and their functions given to one or another of eight departments. The State Board of Health became the Division of Public Health under the Department of Commerce and Industry, with the Lieutenant Governor (Clifford M. Townsend) in direct charge. This arrangement continued for several years but did not function well because all of the State health laws were written in the name of "the Indiana State Board of Health." This arrangement was reversed and the original set up again after the action of the General Assembly of 1941.

When the health work was under the Lieutenant Governor, the "Board" consisting of four members were essentially without power and no appointments to the "Board" were made. After a time, however, the Governor was shown the desirability of having such a group in an advisory capacity and three instead of four members were appointed. The number of four was restored after 1941.

Governor McNutt also introduced the policy—still operative—of having close cooperation between the State Board of Health and the Indiana Uni-

versity School of Medicine. This has been a useful device and has done much to take the health work out of politics and to improve the teaching of health to medical students.

Great pressure was put upon the Governor to give jobs to deserving Democrats in the State Board of Health. He is said to have remarked that inasmuch as the Board was 85 percent Republican when he took over, he would be content when he had made the roster 85 percent Democrat. That, it must be admitted, is a tremendous shock to any institution. Persons who were well qualified, and some who were not well qualified, were dropped arbitrarily from the rolls without any warning whatever. In April the axe fell upon Dr. King.

The circumstances surrounding this event are such that the author of this sketch feels a bit of explanation is needed. Governor McNutt had known the present author since college days at Indiana University; he had been on the same faculty with him for a number of years immediately preceding his election to the governorship. The Governor called the author into his office and asked him to become secretary of the State Board of Health. The offer was declined on the grounds that the position was political and therefore not permanent, whereas the position held by the author in the University was one of more dignity and permanency. The author then strongly urged that Dr. King be retained in the office inasmuch as he was the only person in the State trained for such work and that he was a good man for the place. The Governor replied that there were strong political reasons why he must be discharged and also that there were forces in the medical profession who were very anxious that he be removed. He went further to say that there was no use to argue the point because it was all settled, and that if the author would not accept the position he would then ask him to look about the State and help find someone who would be willing and able to take the appointment. It was an important duty if the health structure was to be preserved. Two or three weeks were spent in driving up and down the State interviewing likely persons. Not one was found to be interested with the exception of Dr. John Hare of Evansville, who was already a member of the State Board of Health. Dr. Hare really wanted to be made superintendent of the Southwest Hospital for the Insane located at Evansville, but agreed to take the position temporarily if he were later promised the position at the Hospital. It was understood that he would serve only until July 1 as acting secretary of the State Board of Health.

(To be continued in July issue)

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ONE HUNDRED YEARS OF INDIANA MEDICINE

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V

HISTORY OF THE INDIANA STATE BOARD OF HEALTH

THURMAN B. RICE, M.D.*

(Continued from June issue)

The search now started for a person who would be able to take the permanent appointment. The author called the Governor's attention to a young man, Dr. Verne K. Harvey, who had been his assistant at the Medical School in the Department of Bacteriology. Dr. Harvey had served a year internship in City Hospital and then at the author's suggestion, had accepted the position as State epidemiologist, which position he held until the summer of 1932. At that time, with the aid given by Dr. King and the author, he received appointment to Johns Hopkins University for postgraduate study in health administration. At the time of the crisis in the State government of Indiana, he was still a postgraduate student at Hopkins. It was suggested to the Governor that he be made secretary of the Indiana State Board of Health. The Governor was quite surprised to learn how young he was and that he was in a sense still in school. Furthermore he was amazed to learn that he was probably of Republican affiliation, as certainly his family had been. He was chosen, however, and took office July 1, 1933. He served until October 1, 1940, and during this time succeeded in winning the affection and respect of the physicians of Indiana. He succeeded also in having the State Board of Health regain the good graces of the Medical Association. At the time he took office there was a great program for economy in the government and it was necessary greatly to reduce the budget of the State Board of Health. The annual appropriation was, during the first year of his administration, approximately \$150,000, which seems to be very low for such an extensive undertaking as the State Board of Health had become through the years. During his administration the basic health law of 1935 was passed, which makes the employment of a full time health officer by a county or city permissive but not mandatory. During this entire administration the author served on a part-time basis as advisor to the secretary and also as editor of the *Bulletin of the Indiana State Board of Health*. In 1936 was set up under his direction the Bureau of Health Education closely affiliated with the State Board of Education. This arrangement we believe, was the first of its kind in the United States and has been widely followed and copied since. The new building of the State Board of Health was erected on the Medical Center campus in 1939. In 1940 Dr. Harvey was offered an attractive position as medical director of the

United States Civil Service. He therefore resigned his secretaryship and took this position in Washington where he has served in a distinguished manner since.

Dr. John Ferree, the local health administrator, was chosen as successor to Dr. Harvey. He served approximately two years. During this time World War II was developing and actually had become a reality after Pearl Harbor in December, 1941. Dr. Ferree was eager to join the armed forces and to do what seemed to be his duty in the protection of his country. Finally he accepted a commission as Lieutenant Commander in the United States Navy and in October, 1942, Governor Schricker urged the present author to accept the appointment as acting secretary until such time as a suitable successor could be found. The appointment was a great honor but also a heavy responsibility as in addition to serving as secretary of the State Board of Health and editor of the *Bulletin*, he was professor of Bacteriology and Public Health at Indiana University School of Medicine. His duties during this time of crisis were excessive inasmuch as he was teaching three semesters a year instead of two in the Medical School, and also inasmuch as there was a very great shortage of trained personnel, most of the personnel going into the armed services, of course. If in the years to come it should seem that little progress was made during this time it is to be hoped that the above facts will offer a partial excuse.

During this period the greatest difficulty was experienced in holding the organization together, and in doing on an emergency basis, what simply must be done to protect the health of the public. For some reason which has not been fully explained, the health of the people did remain good during the period. It is to be supposed that the health work of decades past was beginning to have its effect in cleaning up the situation so that it could run for a few years at least, fairly safely on the inertia which it had attained. The arrangement whereby one person should hold full professorship in the University and also be secretary of the State Board of Health obviously was an untenable one except as an emergency measure, and so the incumbent of the secretaryship made strong recommendation to Governor Gates who came into office in January, 1945, that he should seek to secure the services of an individual who could give his entire time to the State Board of Health. It was urged that the importance of the office should call

for a man of first rank and that certain basic changes in legislation and reorganization of the Board should be made. The legislative session of 1945 was most helpful from the health standpoint. A major portion of this credit should be given to Governor Ralph Gates who has been the most health-minded Governor that the State has ever had, and probably the most health-minded Governor in the entire United States. Great progress in the direction of better health has been made under his administration. Too much credit cannot be given him in this connection.

Finally at the recommendation of Dr. Rice, Dr. L. E. Burney, at that time director of the New Orleans District of the United States Public Health Service and bearing the equivalent rank of full Colonel in the Army, was chosen as Health Commissioner. Dr. Burney took office July 1, 1945. He continues to serve with distinction to the present time.

Inasmuch as his administration is current and it is impossible to evaluate progress so recently attained, we shall do no more than mention a very few of the signal attainments which have been made since his administration began. First, there has been a very great increase in the number of the personnel who are helping with the health work. This is made possible by the release of competent persons who were serving in the armed forces. Second, the districts which had been set up in southern Indiana were discontinued and the entire State divided into five branches with offices at Washington, Valparaiso, Terre Haute, Columbus and Fort Wayne. Third, a marked increase in appropriation was made by the Legislature of 1947. The appropriation is now approximately twice what it has been in previous years. Fourth, the building occupied by the State Board of Health since 1939, is to be given to Indiana University School of Medicine as an administration building and a new and much larger building erected adjacent to the Medical Campus on West Michigan street. Fifth, a division having to do with hospital administration and given the responsibility for hospital licensure and making a hospital survey to determine where such institutions are needed was set up. Likewise, a Division of Geriatrics and Adult Hygiene has been established and this bureau later divided so as to set up a separate bureau on cancer control. Other changes in internal organization have been effected. Since the reorganization of the Board in 1945 the State Board of Health has consisted of three physicians, one dentist, one veterinarian, one pharmacist, one sanitary engineer, one nurse and one layman.

We are very anxious indeed to make an honest estimate of the State Board of Health as it has progressed through the years. When it was taken over by Dr. Hurty in 1896 it was certainly at an extremely low ebb, but we must remember that most state boards of health at that time were in a similar position. During the administration of Dr. Hurty it attained great prominence and became

one of the foremost boards of health in the United States. Undoubtedly Dr. Hurty, during his latter years, was considered one of the two or three outstanding health officials in the Union. In the years since, it is entirely possible that we have too much honored the memory of this good man and have been somewhat unprogressive for the reason that we have tried to do things as he would have tried to have done them in his time, though he himself wouldn't have approved of such an arrangement at all. Very probably it is an accurate statement to say that we have smothered progress in his holy ashes. It is true that we have gone forward and I think it is fair to say that we have gone forward rapidly, but we have not progressed as rapidly as have other states, with the result that while we have advanced we have lost *relative* position. For one reason or another Indiana health affairs are *not what they should be*. This is not the fault of any one individual at all, nor is it the fault of a group of individuals; rather it is due to the fact that the people of Indiana have not been as willing to support the State Board of Health with public funds as have the people in other states, even the adjoining states. It is obviously a fact that one can buy more goods with a dollar than he can with thirty cents, and this applies to health work as well as to any other. In recent years the expenditure for central health administration has been about ten or eleven cents per capita, and then we have had additional help from the federal government to bring it up to about a total of thirty cents per capita. This is definitely not enough. In 1945 only three other states in the Union spent less money for health administration than did we. Several states of far lower economic status were spending as much as two or three times as much as we for health. In recent years it may be said that we have made great progress toward better health, and that we have every reason to believe that if this work should continue, within a few years Indiana will be in the upper third of states in this regard. Certainly it deserves no less position. The medical profession must provide leadership in such matters, and the people demand that the health of the State shall be placed on the highest level reasonably attainable.

INDIANA STATE BOARD OF HEALTH

J. W. Compton, M.D., Evansville	1882-1883
Thaddeus M. Stevens, M.D., Indianapolis	1882-1883
Wm. Lomax, M.D., Marion	1882-1886
W. W. Vinnedge, M.D., Lafayette	1882-1883
J. M. Partridge, M.D., South Bend	1882-1883
E. S. Elder, M.D., Indianapolis	1883-1884
Samuel R. Seawright, M.D., Lafayette	1884-1892
C. N. Metcalf, M.D., Indianapolis	1884-1895
W. A. Fritsch, M.D., Evansville	1884-1888
S. S. Boots, M.D., Greenfield	1884-1892
John N. Taylor, M.D., Crawfordsville	1887-1893
T. J. Dills, M.D., Fort Wayne	1891-1892
L. L. Whitesides, M.D., Franklin	1893-1896
D. C. Ramsey, M.D., Mount Vernon	1893-1896

J. N. Hurty, M.D., Indianapolis	1896-1922	T. W. Oberlin, M.D., Hammond	1930-1932
T. Henry Davis, M.D., Richmond	1895-1915	A. C. McDonald, M.D., Warsaw	1932-1933
John H. Forrest, M.D., Marion	1895-1902	John H. Hare, M.D., Evansville	1932-1933
H. Jameson, M.D., Indianapolis	1897-1899	Frank W. Cregor, M.D., Indianapolis	1932-1933
E. D. Laughlin, M.D., Orleans	1897-1901	J. C. Glackman, M.D., Rockport	1933-1941
W. N. Wishard, M.D., Indianapolis	1900-1911	Ernest Rupel, M.D., Indianapolis	1933-1945
Clark Cook, M.D., Fowler	1901-1903	Edmund Van Buskirk, M.D., Fort Wayne	1933-1945
Chas. M. Eisenbeiss, M.D., Indianapolis	1903-1905	William Wise, M.D., Indianapolis	1937-1941
F. A. Tucker, M.D., Noblesville	1904-1912	Herman Baker, M.D., Evansville	1941-1945
George T. McCoy, M.D., Columbus	1906-1909	Henry C. Metcalf, M.D., Connersville	1941-1944
James S. Boyers, M.D., Decatur	1911-1919	Harry Plummer Ross, M.D., Richmond	1944-1945
John R. Hicks, M.D., Covington	1911-1913	(Note: In 1945 the Board was reorganized to consist of nine members with staggered terms—3 physicians, 1 dentist, 1 veterinarian, 1 pharmacist, 1 sanitary engineer, 1 nurse and 1 layman.)	
H. H. Sutton, M.D., Aurora	1913-1916	David R. Johns, M.D., East Chicago	1945-
J. L. Freeland, M.D., Indianapolis	1914-1916	Howard Johnson, Mooresville	1945-
Chas. B. Kern, M.D., Lafayette	1915-1923	Don E. Bloodgood, B.S.C.E., C.E., Lafayette	1945-
Hugh A. Cowing, M.D., Muncie	1916-1924	W. B. Currie, D.D.S., Indianapolis	1945-1947
John A. Hewett, M.D., Terre Haute	1917-1923	Mary Heckard, R.N., Indianapolis	1945-
Frederic R. Henshaw, D.D.S., Indpls.	1919-1920	Glenn L. Jenkins, Ph.D., Lafayette	1945-
Adah McMahan, M.D., Lafayette	1921-1924	R. C. Julien, D.V.M., Indianapolis	1945-
John H. Green, M.D., North Vernon	1923-1931	Jacob T. Oliphant, M.D., Farmersburg	1945-
T. Victor Keene, M.D., Indianapolis	1923-1927	James L. Wyatt, M.D., Fort Wayne	1945-
Homer C. Haas, M.D., Peru	1925-1926	Maynard Hine, D.D.S., Indianapolis	1947-
James A. Turner, M.D., Nashville	1925-1928		
A. J. Hostetler, M.D., Lagrange	1927-1932		
Cavins R. Marshall, M.D., Indianapolis	1928-1931		
John W. Iddings, M.D., Crown Point	1929-1930		

VI

THE STATE BOARD OF MEDICAL REGISTRATION AND
EXAMINATION

RUTH V. KIRK*

THE State Board of Medical Registration and Examination was created by an Act of the General Assembly of Indiana on March 8, 1897; an Act regulating the practice of medicine, surgery and obstetrics; providing for the issuing of licenses to practice; providing for the appointment of a State Board of Medical Registration and Examination, and defining their duties; defining certain misdemeanors and providing penalties; and repealing all laws in conflict therewith and certain acts therein specified.

Within thirty days after the passage of this Act, five reputable physicians, graduates of reputable schools of medicine, were appointed by the Governor of Indiana, James A. Mount, as provided in Section Four of the Act.

The Act provided that subsequent to March 8, 1897 and prior to July 11, 1899 all physicians hold

ing licenses from their respective circuit court clerks surrender such licenses to the Board of Medical Registration and Examination, for which such Board would issue a new certificate under terms and conditions of the Act; and that subsequent to July 11, 1899 all applicants for licensure be required to meet the standards established by said Board for obtaining licensure; said Board having been charged with establishing minimum requirements, from time to time, and maintaining a record of requirements which must be complied with by applicants for a license to practice medicine, surgery and obstetrics. The State Board of Medical Registration and Examination is charged with the administrative function under provisions of the Act.

The following changes to the Medical Practice Act have been made by the General Assembly of Indiana:

In 1899 an Amendment provided for the licensing of midwives in the state of Indiana.

* Indianapolis. Executive Secretary of the State Board of Medical Registration and Examination.

On March 4, 1905 an Amendment provided for the issuing of licenses to practice osteopathy (only); and provided for an additional member, the member to be so appointed to be a reputable practicing physician, and a graduate of a reputable school or college of the system by which he practices.

On February 27, 1909 an Amendment empowered said Board to restore a licensed physician to his former rights under his license, where his or her license had been revoked under provisions of Section Five of this Act.

On March 5, 1923 an Amendment provided for the issuing of licenses to practice "Osteopathy, Surgery and Obstetrics, and to administer Antiseptics, Anesthetics and Narcotics," under terms and conditions as set forth in the Amendment.

On March 11, 1927 an Amendment provided for the issuing of licenses to practice drugless healing; and provided for an additional member, such appointee to be a reputable practitioner of the system or method of healing not heretofore represented on the Board.

On February 26, 1945 an Amendment provided for the issuing of licenses to practice "Osteopathy, Medicine, Surgery and Obstetrics."

On February 28, 1945 an Act was passed by the General Assembly abolishing the State Board of Medical Registration and Examination, and creating the Board of Medical Registration and Examination of Indiana and prescribing its duties. All the rights, powers and duties heretofore conferred by law upon said State Board of Medical Registration and Examination continued in full force and effect and transferred and conferred upon the Board of Medical Registration and Examination of Indiana, hereby created.

On March 13, 1947 an Act was passed concerning the annual registration of all holders of certificates of any kind issued by the State Board of Medical Registration, and by the Board of Medical Registration and Examination of Indiana, and the payment of fees therefor.

The following Rules and Regulations have been adopted by Board action; the Board being empowered to adopt Rules and Regulations that have force and effect of law, provided such rules are adopted not later than the annual meeting of Board the second Tuesday in January of each year, and provided they do not conflict with statute:

The examination method for procuring medical license became operative March 11, 1901. In 1904 rules were adopted providing for reciprocity in medical licensure between Indiana and other states maintaining equivalent standards (as of January 1, 1948, Indiana reciprocates with some thirty-eight states); as well as recognition of National Board certificate holders, on the basis of reexamination in accordance with provisions of Chapter 253 of the Acts of 1947.

The minimum standards established by the Board for graduates of medical schools matriculating prior to February 1, 1903 specified Common

School course; subsequent to February 1, 1903 and prior to January 11, 1910 High School diploma; subsequent to January 11, 1910 and prior to January 1, 1911 documentary evidence of completion of the freshman year in a recognized college of arts and sciences (credits earned in professional schools not acceptable as premedical preparation); subsequent to January 1, 1911 and prior to January 10, 1917 completion of one-half the work in a recognized university or college of arts and sciences necessary to obtain the B. S. degree in such university; subsequent to January 10, 1917 sixty semester hours in a recognized university or college of arts and sciences, and such work to include a minimum of eight hours in chemistry, four hours in biology, and four hours in physics.

After January 15, 1914 all preliminary qualifications as outlined must in all cases be completed prior to matriculation in the medical course. Indiana does not require internship, nor does it require citizenship, as prerequisite to medical license.

On January 11, 1938 a Ruling was adopted pertaining to licensure of graduates of schools located outside the United States and Possessions; requiring that such graduates meet the standards of the Indiana Board and, in addition thereto, repeat the senior year of medicine in an American medical school recognized by said Board to be eligible for examination. On January 12, 1943 this Ruling was modified (for the duration of the Emergency) to permit admission of graduates who obtained their entire medical course in a recognized medical school of Canada to examination without repeating the senior prescribed year of medicine, as set forth in original ruling. The number of applicants who were foreign school graduates greatly increased about 1938 and this Ruling proved of great value to the Board, as it was practically impossible to obtain sufficient information and documents to properly evaluate qualifications in conformity with requirements of this Board.

On January 13, 1942 an Emergency War Ruling pertained to requirements during the accelerated program under which all medical schools operated.

The 1945 session of the General Assembly passed an Act providing that all administrative Boards, including the Board of Medical Registration and Examination, propose any new Rule, publish it in a regularly circulated newspaper at least ten days in advance of a public hearing date on the proposed ruling, after which the ruling be adopted, submitted to the Attorney General of Indiana for legal approval and signature, also to the Governor for his signature, then file with the Secretary of State and the Legislative Reference Bureau; then only does it become a Ruling with effect of law.

Since the inception of the Board 15,360 certificates to practice medicine have been issued. As of January 1, 1948 there were 3,826 medical licensees registered under the 1947 Annual Registration Act, living within the state of Indiana; and 212 registered that are residing in other states. During the

life of the Board some 200 physicians have had their license revoked, with perhaps twenty-five per cent of them restored.

Approximately 200 osteopaths have been granted license under the 1923 Amendment heretofore described; and 43 licenses to practice osteopathy, medicine, surgery and obstetrics, under the 1945 Amendment, have been issued. As of January 1, 1948, 71 of the first group, residing in Indiana, had registered, and 14 residing in other states. Of the latter group 39 licensed under the 1945 Act, residing in Indiana, and 2 residing outside the state, had registered.

Since the 1927 Amendment providing for the licensing of drugless practitioners 1,393 certificates have been issued, including chiropractors, naturopaths, neuropaths, physiotherapists, mechanotherapists, and kindred branches; and of that number registered as of January 1, 1948 there were 464 Indiana residents and 33 non-resident.

The author of the Medical Practice Act, and the one responsible for the efforts and success in its enactment, was William Niles Wishard, Sr., Indianapolis.

Miss Myrtle Clark was appointed clerk in 1910 and served until 1919. Miss Lucy Campbell served as clerk from 1919 until 1929. Myrtle Clark Griggs returned in 1929 and remained as clerk until 1933. Ruth V. Kirk was appointed clerk in 1933, was named executive secretary in 1937, and has served continuously in that capacity since 1937. The Board was housed in various locations of the State Capitol until May, 1946, at which time the offices were moved to the Knights of Pythias Building, Indianapolis.

The appointees, or personnel, of the Board of Medical Registration and Examination covering the entire time of existence, are as follows:

J. C. Webster. 1897-1909. President 1897, 1900, 1903, 1906.

W. T. Gott. 1897-1933. President 1898, 1901. Secretary 1902-33.

W. A. Spurgeon. 1897-1933. President, 1899, 1902, 1905, 1908-09, 1912-13, 1915, 1921-33.

J. M. Dinnen. 1897-1920. President 1907, 1910-11, 1914, 1916-18.

W. F. Curryer. 1897-1902. Secretary 1897-1901.

M. S. Canfield. 1903-20. President 1904.

J. E. P. Holland (first Osteopath). 1905-09.

S. G. Smelser. 1910-20.

J. F. Spaunhurst (Osteopath). 1910-16.

A. B. Caine (Osteopath). 1917-21. President 1919-20.

V. P. Shanklin. 1921-29.

F. S. Crockett. 1930-37.

Paul R. Tindall. 1921, 1943-48. Secretary 1946-48.

W. R. Davidson. 1921-37.

J. W. Bowers. 1922-42. President 1934. Secretary 1941.

J. B. Kinsinger. (Osteopath), 1922-33.

C. J. Vantilburg (first Chiropractor). 1927-37.

L. C. Sammons. 1934-37.

N. E. Harold. 1934-45.

E. O. Peterson (Osteopath). 1934-37.

J. T. Oliphant. 1938-40. President 1938-40.

W. C. Moore. 1938-45.

J. M. Hicks. 1938-41.

C. B. Blakeslee (Osteopath). 1938-48.

H. K. McIlroy (Chiropractor). 1938-41.

H. C. Ruddick. 1941-48. President 1941-48.

H. W. Eickenberry. 1942, 1946-48.

J. W. Webb. 1943-46.

C. F. Aumann (Chiropractor). 1943-48.

Will A. Thompson. 1946-48.

W. N. Wishard, Jr. 1946-48.

(Note: Doctors Gott, Spurgeon, Dinnen and Bowers served more than twenty years.)

VII

REGULATION OF THE PRACTICE OF MEDICINE IN INDIANA SINCE 1897*

ALBERT STUMPF†

THE basic Medical Practice Act in the present structure of medical practice laws of Indiana is the Act of March 8, 1897. Under that Act a State Board of Medical Registration and Examination of five members was created. Each of the four schools, or systems, of medicine then in existence having the largest numerical representation in the state was required to be represented on the Board. The four schools, or systems, referred to were the

homeopathic, eclectic, physio-medical, and allopathic—the latter being a name coined by Dr. Hahnemann, the founder of homeopathy, to characterize the regular physicians who were not homeopaths.

Under the 1897 Act those who were already practicing under a license issued under the preceding law were granted certificates by the new State Board. Those who desired to enter the prac-

tice after the 1897 Act were required to submit to the Board a diploma showing graduation from a medical college recognized as maintaining a satisfactory standard of medical education as defined and fixed in the records of the Board. If a diploma was from a substandard school, then the applicant for a certificate was entitled to take an examination. If he passed the examination successfully he was then entitled to a certificate.

The certificate for a license is presented to the Clerk of the court in the county in which the physician resides, and the Clerk thereupon issues the license authorizing the physician to practice throughout the entire state. His license is to practice in the state although it must be issued by the Clerk of the county in which he resides. If he moves from one county to another he must get a new license in the new county of residence. He is not required to obtain a new certificate.

The 1897 Act was amended in 1899, but not in any particulars of significance with respect to the regulation of the practice of medicine. The dates of the meetings of the Board, the compensation paid to the Board, and a few matters of that kind only were involved in the 1899 Act.

The 1897 Act and the 1899 Act were both amended under one title in the 1901 Act. The important change in the 1901 Act was in the change of requirements to obtain a certificate. Under the 1901 Act no one could take an examination after January 1, 1905 who was not a graduate of a recognized school. Neither could a certificate be obtained without an examination. That feature of the Medical Practice Laws is still in force and effect. Under that law the fixing of the standards upon which schools will be recognized by the State Board is of great importance. For only graduates from recognized schools have been able to obtain licenses except those who came in under the grandfather clause of the 1927 Act, which will be discussed later.

On March 4, 1905 an Act was approved increasing the number on the Board from five to six. The additional member was an osteopath. That Act also provided that osteopaths holding diplomas from colleges of osteopathy recognized by the Board should be eligible to take an examination, and to obtain a certificate for a license to practice osteopathy, if the examination was passed successfully. There was no definition of osteopathy in the 1905 Act and none has been included in any subsequent Act.

The osteopathic provision of the Medical Practice Law was amended in 1923 to provide that osteopaths should have the right to practice osteop-

athy, surgery and obstetrics, and to use in their practice anesthetics, antiseptics and narcotics.

This law pertaining to osteopaths was further amended in 1945 by a provision under which osteopaths are permitted to take an examination in materia medica, and, if they pass the examination successfully, to receive a certificate for a license to practice osteopathy, medicine, surgery and obstetrics without limitation. The osteopath, however, cannot take an examination unless he is a graduate from a school recognized by the Board, which teaches all the subjects required in a recognized school and whose requirements for admission and graduation are the same as the minimum requirements for a regular medical school.

The State Board of Medical Registration and Examination was authorized in the Act of 1897 to fix the minimum requirements for recognition of medical colleges. The law in that regard remains unchanged. The Board has made the same minimum requirements for recognition for all schools teaching any form of healing. Prior to 1945 the colleges of osteopathy were required to give courses covering the same amount of time as required by medical schools and covering all the subjects required in medical schools except materia medica. Under the 1945 Act the osteopathic schools are required to include materia medica. This makes it necessary for osteopathic schools to maintain the same standards as are required in the medical schools. But there are no standards fixed by the Board regarding the amount of time to be given to the subject of osteopathy itself nor what must be taught regarding that subject. That is left to the discretion of the school, without any provision in the law for a standard with which any school must comply.

The Indiana law does not require that one have a degree of M.D., or of D.O., or of any other kind. It does require graduation from a recognized school. And as a matter of course graduation universally implies the conferring of a degree.

In 1909 the State Board was given power to restore licenses to physicians where the licenses had been revoked by the Board.

In 1927 the Medical Practice Laws were amended to authorize the issuance by judges of injunctions against the unlawful practice of medicine. Therefore the only penalty for the unlawful practice of medicine, was a fine of not less than \$25.00 nor more than \$200.00, which penalty has been included as a part of the 1897 Act and which has not been changed. The penalty was ineffectual to prevent the practice of medicine without a license. One of the disadvantages in the enforcement of the law, which contained no method of enforcement except the sanction of a penalty, is that a person charged with a crime, even though the crime be only a misdemeanor, as the unlawful practice of medicine was declared to be in the 1897 Act, is that whoever is charged with a crime has a right to a trial by jury. Convictions are difficult to get on a charge of the crime or mis-

* A discussion of regulations before 1897 appeared in the *Journal of the Indiana State Medical Association*, February, 1949, p. 138: Clutter, Raymond O., "The History of Medical Jurisprudence in the State of Indiana during the Nineteenth Century."

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demeanor of practicing medicine without a license. A conviction cannot be had without the unanimous verdict of twelve jurors. If any one of the jurors refuses to join in a verdict of guilty, no such verdict can be returned.

Injunction is a procedure in equity and not in law. In equity cases the judge alone decides the case, and a jury cannot decide it. It became obvious in Indiana that the effectual means for the enforcement of the Medical Practice Law required that that enforcement be put upon a basis other than enforcement by a criminal penalty. Under the injunction law the court hears the case and decides whether the person charged has in fact been practicing medicine without a license. If he finds that to be true, then it is his duty to order such practitioner to quit practicing. This order is enforced thereafter by contempt proceedings through which the Judge compels obedience to the order. The adoption of such a law was of the utmost importance if the medical law was to be enforced. No bill ever was fought by cultists with greater determination in the Legislature than this bill for injunctive procedure in enforcement of the Medical Practice Laws. In the House of Representatives it received 51 votes, the minimum constitutional vote necessary for passage. An effort has been made by cultists in every session of the Legislature since that date either to repeal the law or to get a separate board created for chiropractors and other cultists. None of the efforts have been successful.

In order to get the 1927 Act providing for injunction passed, it was necessary to make some compromises. One of the compromises was that those who on January 1, 1927, had been engaged in the practice of chiropractic or other cultist forms of so-called healing and were graduates of a school teaching system or methods they were using, should be granted licenses limited to the practice they had been following and had been taught in their schools. Under this grandfather clause quite a number of chiropractors and other cultists who claimed they had graduated from schools entitled to be recognized as such, were granted certificates for limited licenses.

Another compromise necessary to obtain the passage of the 1927 Act was to include on the Board a chiropractor. The Board now has seven members.

No school teaching chiropractic, naturopathy, and like cultist practices has ever been organized that maintains standards high enough to satisfy the requirements of the State Board. Therefore, no graduates of such schools have ever been admitted to the examinations of the Board, nor have any ever been licensed except under the grandfather clause. Of course if the schools in these cultist fields would establish standards of education that complied with the requirements of the Board their graduates would have the same right to take the examinations as the graduates of regular medical schools and osteopathic schools.

In 1945 the State Board of Medical Registration and Examination was abolished, and all its powers

were transferred to the Board of Medical Registration and Examination of Indiana. This Board was constituted of seven members, five of whom are reputable physicians who are graduates of recognized medical colleges with the degree of Doctor of Medicine; one of whom is a reputable osteopathic physician who is a graduate of a recognized school of osteopathy with a degree of Doctor of Osteopathy; and one of whom is a reputable chiropractor who is a graduate of a school teaching that system. All the appointees must hold licenses: the physicians, unlimited licenses; the osteopathic physician, a license to practice osteopathy; and the chiropractor, a license to practice chiropractic.

The change in the Medical Practice Laws made in 1945 had become necessary because of the historical development of medical education that had taken place since 1897. The 1897 Act had become obsolete through the fact that the four distinct schools of medicine recognized in 1897 no longer existed as separate and distinct schools. The last of the eclectic and physio-medical schools had disappeared. Most of their graduates had died or were reaching such ages that they did not accept appointments upon the Board. The time had been reached when the Board as a practical matter could be constituted only with great difficulty as then required by the law, and it was obvious that within a very few years it would be entirely impossible to constitute the Board by inclusion upon it of other than regular physicians. In the 1945 Act all recognition of divisions within the regular practitioners of medicine is disregarded and the five doctors of medicine are no longer classified as representatives of any particular school or method of medical practice.

In 1947 an Act was passed requiring annual registration of all who have a certificate for a license to practice the healing art in any form or manner. This law covers not only the regular physicians but also chiropractors, naturopaths, and every school or cult of any kind whose members have received or will receive while the law is in effect, a certificate for a license of any kind. The fee for registration is \$5.00 annually and is payable on or before August 31st of each year. The fee for all applicants who desire to keep their certificate in force in Indiana but who reside outside of Indiana is \$10.00 annually. A failure to comply with the Act automatically cancels the certificate and license issued thereunder. A certificate cancelled for failure to register may be reinstated by the Board upon submission of the applicant's last registration certificate and the payment of the current and delinquent fees and an additional fee of \$10.00.

Prior to this 1947 Act there was no record available of the number of physicians practicing in the State of Indiana. A physician was granted a certificate for a license. A record was made of the fact. No further official record was made in the office of the Board unless the certificate was revoked. There was no way to find whether the

certificate holder remained in the state, or moved out of the state, or died, or abandoned the practice of medicine. The annual registration law, in addition to raising funds through which the Medical Practice Laws may be enforced, also produces the statistical data regarding the number of physicians and of other types of practitioners lawfully engaged in the healing art some time during the year.

The enforcement of the Medical Practice Laws of the State of Indiana has been made much easier through the injunction law of 1927. Cases may be brought by the prosecuting attorney, by residents of the county in which the practitioner resides, and by the Board of Medical Registration and Examination, against those who practice without a license, for an injunction against such practice. No cases have been filed that have not been won, either in the trial court or upon appeal, under that law. So effective has been the prosecution of cases under this law that notice to an unlawful practitioner of intention to bring suit is usually sufficient to cause him to discontinue the practice or move out of the state.

To keep this law upon the statute books has required constant vigilance and effort on the part of those interested in maintaining proper standards for the care of the sick and in protecting the public against fraud and imposition. The members of the medical profession have not brought actions themselves. It has been thought unwise for them to do so, on the ground that it might create a public reaction based on a view stimulated by the cultists that the medical profession was persecuting those who might be regarded as their competitors. Physicians to whom patients come who have been victimized through unlawful practice by cultists have been encouraged to report the information given to them to the Board of Medical Registration and Examination, with the consent of the patient. With the additional funds made available through the annual registration law, the Board has been able to have investigation made immediately and action brought where that was deemed advisable.

The Indianapolis Better Business Bureau has for many years given much attention to the suppression of the unlawful practice of medicine, and also to the revocation of licenses of physicians and cultists who departed from the standards of medical ethics to the extent that their conduct became grossly immoral. Mr. Toner M. Overley, manager of the Better Business Bureau, has for many years been a tower of strength in the protection of the public against quackery and charlatanism, whether by cultists or by regularly licensed M.D.'s. He has displayed the hardihood necessary for the enforcement of the law by filing verified charges under his own name against both physicians and cultists for the revocation of their licenses where the facts warranted it, and has brought to a successful conclusion all the cases he has instituted. Some of them have attracted national attention. All of

them taken together have helped to build up a body of decisions which have established the law in the state of Indiana clearly and with such strength that the Indiana law upon that subject could scarcely be made more clear and forceful. He deserves the gratitude and thanks of the public.

Attention is invited to a few of the cases decided by the Indiana Supreme Court in establishing the law as to what type of conduct is included in the statutory grounds for the revocation of a license. The statute provides that a license may be revoked for any of the following causes:

1. The fact that the license was obtained by fraud.
2. Conviction of the licensee of a felony.
3. Addiction to the use of liquor or drugs to such an extent as to render him unfit to practice medicine or surgery.
4. Conduct which is grossly immoral.

The last of these four grounds for the revocation of a license presented the necessity for judicial construction as to what constituted gross immorality. The Supreme Court has held that misrepresentation as to the scope of one's license to practice, violation of the narcotic laws, deception and fraud in the practice of medicine, departure from the recognized methods of treatment for one's own personal profit and not for the benefit of the patient, and any other conduct which would be characterized by persistently unjust, dishonest and wrongful acts, constitute gross immorality.

In the case of *Crum v. State Board of Medical Registration and Examination* (1941) 219 Ind. 191, 37 N.E. (2d) 65, the Supreme Court of Indiana had before it the question of gross immorality in the use of a fraudulent device called a co-etherator. The court in that case applied the following as a definition of gross immorality:

"Immorality as defined by Webster is 'the quality of being immoral'; 'an immoral act or practice.' Immoral is defined by the same authority as 'not moral'; 'inconsistent with rectitude'; 'contrary to conscience or the divine law'; 'wicked', 'unjust'; 'dishonest'; 'vicious.' Immorality as defined by lawwriters is 'that which is contra bonas mores'; 'an act or practice which contravenes the divine command or social duties.' Immoral, as that which is 'hostile to the welfare of the general public'; 'wicked'; 'unjust'; 'dishonest'; 'vicious'; 'unjust in practice.' 'Gross' as used to modify the word 'immorality' does not mean great or excessive, but rather wilful, flagrant, or shameless, showing a moral indifference to the opinions of the good and respectable members of the community."

This *Crum* case should be read by all who are interested in how far human credulity may be carried. The "doctor" in this case used a small wooden box in the manner thus described in the opinion:

"The usual method for treating human ailments was to have the patient moisten a slip of paper with saliva and deposit it through a slot on the top of the box, although it was claimed by the appellant that the same results could be obtained by similar use of the patient's photograph or a specimen of his handwriting. After this was done, the appellant rubbed the pedal with his thumb and talked to the machine, repeating the popular names of diseases and organs of the body. Among the diseases which the appellant claimed to be able to treat and relieve, and in some instances cure, by this method were cancer, blindness, arthritis, nervous disorders, hemorrhoids, abscesses, kidney ailments, stomach disorders, leakage of the heart, skin ailments, ovarian trouble, varicose veins, and tumors. He asserted that he could lengthen or shorten a patient's legs; cause amputated fingers to grow back into place; and fill cavities in teeth, not with a foreign substance but by restoring them to their original condition. He said that it was not necessary for patients to be present or to visit his office, but that he could broadcast treatments to them wherever they might be located. The appellant's practice was not limited to the treatment of human ills. He also claimed to be able to administer 'financial treatments,' by means of which money could be put into the hands of his patients; that he could fertilize fields to a distance of seventy miles; kill dandelions over any particular area; and treat golf greens as far from Indianapolis as Decatur, Illinois, so that clover would turn brown and dry up and give the grass a chance to grow."

"Doctor" Crum was a man without education except such as might be indicated by the fact that he had attended the "College of Drugless Physicians" in Indianapolis, which the court in this case indicated was only a diploma mill, from which he had graduated at the end of one year with the following doctors' degrees: Doctor of Naturopathy, Doctor of Therapeutics, Doctor of Chiropractic, and Doctor of Herbal Materia Medica.

One of the cases attracting nationwide attention in which gross immorality was the basis for the revocation of physicians' licenses involved two doctors of medicine in Indiana. They were Dr. Charles F. Kaadt and Dr. Peter S. Kaadt, two brothers who held themselves out as specialists in the treatment of diabetes. They claimed to have a method by which diabetics could avoid the unwelcome necessity for adhering to diet regulations and for having insulin treatments by hypodermic needle. Their treatment consisted substantially of the use only of saltpeter and vinegar, which they sold to their patients in gallon quantities at \$30.00 per gallon.

That case was brought by Toner M. Overley in his individual capacity. The Board revoked the license of Dr. Peter S. Kaadt. He took an appeal to the Circuit Court and it ordered the license restored. An appeal was taken from the Circuit Court to the Supreme Court, and the Supreme Court reversed the judgment of the Circuit Court and ordered the trial court to sustain the action

of the Board revoking the license. Charles F. Kaadt surrendered his license at the time the case against him was opened for trial before the Board.

The opinion in the Kaadt case has been highly praised among those interested in the problem of the suppression of fraud, quackery and charlatan-ism in medicine. The case was decided January 15, 1948. It is cited as Board of Medical Registration and Examination v. Kaadt, 76 N.E. (2d) 669. The opinion contains a statement of the charges which may be summarized as follows:

(a) That Dr. Peter S. Kaadt held himself out as a specialist using a treatment making it unnecessary for the restriction of diet or the use of insulin injections—all of which was false.

(b) That he caused diabetics to neglect proper treatment and thereby injured them through delay in obtaining proper treatment.

(c) That he misrepresented to his patients the nature of diabetes.

(d) That he neglected to use care in diagnosing his patients.

(e) That he misrepresented the medicinal value and the monetary worth of his medicines and induced the patients to pay exorbitant prices, all to his own personal gain and without regard to the welfare of his patients.

(f) That he deceived and misled his patients and caused them to go out and induce other like sufferers to obtain his treatment, in spite of the fact that those actually suffering from diabetes were gradually growing worse.

The court held that these acts constituted gross immorality. The court emphasized the facts (a) that the doctor knew that what he was representing was not true; and (b) that the medical men who constitute the Board, act, in the revocation of a license, in an administrative capacity, and that their decision should not be disturbed by the judge, who with respect to medicine is a layman, if there is any basis whatever on which to sustain the act of the administrative Board. In that connection the court quoted from the celebrated case of *Brinkley v. Hassig*, 83 Fed. (2d) 351. This case is the goat gland case, and Brinkley is the notorious Dr. Brinkley of goat gland fame.

This Kaadt opinion with the excerpts from the Brinkley and another case quoted in it establishes the law to the effect that the decisions of the Board, being made up of medical men, will be respected and enforced by the courts. The part of the opinion, important with respect to the legal questions involved, is a splendid statement of the law, and very interesting. It deserves a place in this article, and therefore the following is quoted from it.

"The important question at issue is what the appellee knew to be the facts. If the treatment which he afforded was not a cure or a proper remedy for diabetes and he

knew this to be the truth then he was guilty of a scheme to defraud. *Samuels v. United States*, 8 Cir., 1916, 232 F. 536, 545, Ann. Cas. 1917A, 711.

"It has been said: 'That false and fraudulent representations may be made with respect to the curative effect of substances is obvious. It is said that the owner has the right to give his views regarding the effect of his drugs. But state of mind is itself a fact, and may be a material fact, and false and fraudulent representations may be made about it; and persons who make or deal in substances or compositions alleged to be curative are in a position to have superior knowledge, and may be held to good faith in their statements (citing authorities). It cannot be said, for example, that one who should put inert matter or a worthless composition in the channels of trade, labeled or described in an accompanying circular as a cure for disease, when he knows it is not, is beyond the reach of the lawmaking power.' Seven cases, *Eckman's Alternatives v. United States*, 239 U.S. 510, 36 S.Ct. 190, 60 L. Ed. 411, L.R.A. 1916D, 164.

"The appellee lays great stress on the contention that to empower the appellant to pass upon his good faith in what he is charged with having done would have a crippling effect upon the advances in medical science, as it would prevent the use of new remedies. With this we cannot agree. A physician is not limited to the most generally used of several approved modes of treatment and the use of another mode known and approved by the profession is proper, but every new method of treatment should pass through an experimental stage in its development and a physician is not authorized in trying untested experiments on patients. 41 Am. Jur. Physicians and Surgeons, Sec. 86.

"The case of *Brinkley v. Hassig*, 10 Cir., 1936, 83 F.2d 351, involved the question of the revocation by the Kansas State Medical Board of the license of one John R. Brinkley to practice medicine. The revocation was had under a statute similar to ours.

"We approve of that portion of the opinion found on page 353 of 83 F.2d of said case which reads as follows: 'The Legislature enacted that membership of this board should be confined to physicians and surgeons because they alone have the education and experience to determine such questions as are here presented. Does this record disclose no more than a conflict of opinion among reputable surgeons as to the technique of operative procedure, or as to when it is indicated? Or does it disclose that appellant was using his license to perpetrate a cruel hoax upon the public by exacting extravagant fees for a trivial and worthless operation? Did appellant endanger the health of his patients by seducing them into the belief that serious diseases could be cured by a surgical hocus-pocus? Whether it is the one or the other is a question peculiarly for the decision of men skilled in anatomy. There is a great volume of evidence in this record to support the latter conclusion; and if such is the fact, the board would have been derelict if appellant's license had not been revoked. It is true, as counsel argue, that the great advances in medical science have come about by the courage of pioneers, whose efforts often met with ridicule from their professional brethren. It is true that doctors even yet disagree. It is also true that charlatans masquerading as doctors defraud the public to their own enrichment by promising to cure cancer with innocuous ointments, and thus endanger the lives of their patients by depriving them of sound medical advice. Between these two extremes there is a twilight zone where doubts might perplex. But unless we can say, from the record, that there is no doubt that this is a mere disagreement among doctors, the finding of the board is not open to our review. The Legislature has properly committed the vital question of the fitness of those who administer to the sick to a skilled board of medical men, and not to courts unlearned in the art. The proof here amply supports the conclusion that the compound operation is not an honest effort to relieve the

suffering, but a scheme for appellant's unjust enrichment.'

"It will be noted that the appellee is a man of broad professional experience and has been sufficiently educated in his profession. The board was justified in not attributing the acts complained of to mistake arising out of inexperience or lack of knowledge."

Both the Kaadts were later indicted in the Federal Court under the Food and Drug Law and found guilty on seven counts. At the time this article is being written they are awaiting sentence, the giving of which was delayed to afford them an opportunity to take steps for an appeal.

This review of the history of the regulation of the practice of medicine in Indiana since 1897 demonstrates the interest of the public in suppressing fraud and imposition in that important field; and also the intent of the Legislature and of the courts to make effective that public sentiment. One dark spot in the present prospect is to be found in the fact that substandard schools still exist, although they have almost disappeared from the state of Indiana. It is obviously necessary to keep the practice of medicine upon the basis of complete impartiality with respect to admission to any type of practice, whether scientific or pseudo-scientific. If separate chiropractic boards, or other such cultist boards, are established they always lower the standards for admission into the practice of healing for those who enroll in the cultist schools. If only one Board is given the power to license practitioners and that Board is required to act with impartiality, then all schools that obtain recognition within the state are naturally brought up to the same level of educational requirements. But if a chiropractic school or any other cultist school were really brought up to the same standards as a recognized medical school, the cultist school would not have students and would have to go out of business. The cultist schools thrive only because they offer short-cuts into what they encourage their students to believe will be highly lucrative callings. The system of having easier requirements for some forms of practice itself invites the conscienceless approach toward the practice of some form of cultist healing.

The Indiana medical profession has been diligent, persuasive and effective in the protection of the public against any plan by which separate Boards might throw down the bars to inadequately trained practitioners of healing. This is a matter with respect to which the medical profession owes a definite obligation to protect the public—for the medical profession is in a position to know the importance to the welfare of the public of keeping up the standards of medical care. There is nothing to indicate that the medical profession in Indiana is weakening in its determination to discharge this obligation to the public.

The history of the regulation of the practice of medicine in Indiana since 1897 does credit to the state. It shows that public sentiment in Indiana on the subject of the regulation of medicine, on the

whole is sound, and that the forces of education and enlightenment in the field of medicine have been rather effective in reaching the people whose views constitute the public sentiment out of which

laws and their enforcement originate. Further progress of course is still necessary if the highest ideals of regulation of the practice of medicine is to be attained.

VIII

A HISTORY OF MEDICAL EDUCATION IN INDIANA

BURTON DORR MYERS, M. D.*

AS a bird's eye view of the many ventures in the field of medical education in Indiana, there is here presented, for the purpose of orientation, a chronologically arranged list of titles of the twenty-five schools of medicine that have been chartered in our state.

- 1833- The Christian College at New Albany, chartered by John C. Bennett. Granted medical degrees and diplomas under assumed name, "University of Indiana." Fraudulent. Long extinct.
- 1837- Vincennes University Medical Department, Vincennes.
- 1841-1856 LaPorte University School of Medicine; became the Indiana Medical College in 1846, LaPorte.
- 1849-1854, The Medical College of Evansville; suspended 1854, reorganized 1871, extinct 1884; Evansville.
- 1871-1884
- 1850-1854 The Indiana Central Medical College, Indianapolis. The Medical Department of Asbury College (now DePauw University).
- 1869-1878 The Indiana Medical College, Indianapolis.
- 1873-1909 The Physio-Medical College of Indiana, Indianapolis.
- 1873-1878 The College of Physicians and Surgeons of Indiana, Indianapolis.
- 1876-1883 The Medical College of Fort Wayne, Fort Wayne.
- 1878-1905 The Medical College of Indiana, formed by union of the Indiana Medical College (1869-1878, see above) and the College of Physicians and Surgeons (1873-1878, see above), Indianapolis.
- 1878-1888 The Indiana College of Medicine and Midwifery, Indianapolis.
- 1879-1905 The Central College of Physicians and Surgeons, Indianapolis.
- 1879-1905 The Fort Wayne College of Medicine, Fort Wayne.
- 1880-1890 The Indiana Eclectic Medical College, Indianapolis.
- 1881-1900 The Curtis Physio-Medical Institute, Marion.

- 1882-1886 The Hospital Medical College of Evansville.
- 1883-1886 The Beach Medical College, Indianapolis.
- 1890-1894 The Eclectic College of Physicians and Surgeons, Indianapolis.
- 1894-1897 The American Medical College of Indianapolis.
- 1897-1898 The University of Medicine, Indianapolis.
- 1900-1908 The Eclectic Medical College of Indiana, Indianapolis.
- 1901-1922 The Medical Department, Valparaiso University, Valparaiso — connection with the Chicago College of Medicine and Surgery, Chicago, and later with the Hahnemann Medical College of Chicago.
- 1903 to date The Indiana University School of Medicine, Bloomington and Indianapolis.
- 1905-1908 The Indiana Medical College, School of Medicine of Purdue University, Lafayette.
- 1906-1908 The State College of Physicians and Surgeons, Indianapolis.

Of these schools, one, the Christian College of New Albany, was never organized to teach anything, though for a short time it issued diplomas conferring arts and medical degrees. Two of them, the Vincennes University School of Medicine, and the Indiana University School of Medicine were not organized for many years following authorization by territorial or state Legislatures. Eight schools were very short-lived, having an existence of two, three, or four years. Four schools had an existence of twenty-six to thirty-six years and were finally absorbed in whole or in part by the Indiana University School of Medicine.

The Indiana University School of Medicine, now (1949) forty-eight years old, is, by ten years, the oldest medical school ever organized in the state, and has a capital investment and standing, assuring a future measured by centuries.

The history of medical education in Indiana really began in 1830 with an abortive attempt of the 14th session of the General Assembly to secure a federal subsidy for founding a school of medicine

* Bloomington, Indiana. Dean and Professor Emeritus, Indiana University School of Medicine.

in Indiana. It may be recalled that in 1825 the seat of state government had been moved from Corydon to Indianapolis. Five years later, on January 19, 1830, a Joint Resolution was passed by the General Assembly requesting "our Senators and Representatives in Congress to procure from the liberality of Congress two townships (of land) for the purpose of establishing a medical college in Indiana." The Governor was directed to present the Resolution to our congressmen. A search of the House and Senate Journals reveals the fact that this Joint Resolution was introduced by Mr. Slaughter of Harrison County, on December 26, 1829 (H. J. p. 216). It passed and the House was informed January 19, 1830, that it had been signed by the Governor. The Resolution was transmitted to our Congressmen by Governor Ray. Senator Hendricks, whom James Ray succeeded as Governor of Indiana, "presented the memorial of the Legislature of the State of Indiana" to the U. S. Senate on March 1, 1830.

This was a well-planned and well-executed effort to secure federal aid for establishment of medical education in Indiana, but since favorable action would have established a precedent it is not surprising nothing came of the effort.

It was a time when many entered the practice of medicine after a period of study with a preceptor. At its best this procedure could be very good. For instance, Dr. David H. Maxwell, the first president of the Board of Trustees of Indiana University, had as his preceptor, Dr. Ephraim McDowell of Kentucky, the man who performed the first ovariectomy in America. At its worst it could be very poor as indicated in the following advertisement in the *Richmond (Indiana) Palladium* of January 8, 1831.

"DR. WILLIAM LINDSEY,

"After complimenting his friends for past favors, respectfully informs the public, generally, that he now considers himself permanently located in the town of Richmond, Indiana. In the practice of his profession, in the various branches of PHYSIC, SURGERY and MIDWIFERY. He may at all times be found at his residence and Drug Store, when not absent on business, one door south of Samuel W. Smith's corner, and one door north of Achilles William's saddler shop.

"He still keeps on hand a general assortment of

Drugs and Medicines,

including PAINTS AND DYE-STUFFS, all of which he offers low for cash.

"He has on hands, Dean's Gum Elastic Japan Varnish, for boots, shoes and harness, said to render leather water proof.

"Likewise prepares (himself) an oleaginous Blacking, which renders leather water proof. And can with confidence recommend it to the public as a preservative of leather, superior to anything of the kind he has yet seen. Tanners, Shoe-makers, Harness-makers, and all others, who wish to keep their feet *dry*, would do well to call and examine the article.

"A few young men who are qualified, will be taken as medical students."

While certain men who studied medicine under a preceptor later attended a school of medicine for a short time and received a medical diploma and a medical degree, others passed directly from their

preceptorship into practice with neither diploma nor degree. To cater to the need of this latter group seems to have been the reason at least in part, why certain men secured from the Legislature a charter for the Christian College of New Albany.

THE CHRISTIAN COLLEGE, AT NEW ALBANY, 1833

Twenty miles east of Corydon, formerly the capital of Indiana, was a small settlement, New Albany, which had been incorporated as a town on February 3, 1832, by Act of the General Assembly in the closing days of the sixteenth regular session.

Almost a year later, in the seventeenth regular session of the General Assembly we find an Act to incorporate the Christian College of New Albany, in Floyd County, Indiana, approved January 24, 1833.

Two diplomas, one of which is in Latin, issued by this school and conferring the degree M.D. on an individual named have been preserved. The Latin copy bears the date March 5, 1833, which was just 40 days after the granting of the charter. The title, "Christian College," by which name the institution was to have perpetuity, is discarded in favor of the diploma heading, "University at New Albany, Indiana," and in the body of the diploma this title is abbreviated to the "University of Indiana."

John Cook Bennett was the leader of this scheme and it was often called the Bennett Medical College. There is no evidence that Bennett and his associates ever contemplated organization for medical instruction and it is certain they never did so. It is an error therefore to regard the Bennett Medical School as marking the beginning of medical education in Indiana. The enterprise was merely a phenomenon of human behavior with a profit motive, which appeared in various places at various times. In Indiana it was short-lived and not repeated so far as medical degrees are concerned. We know of no diplomas of this so-called college or university issued after 1833. Dr. Frederick C. Waite of Western Reserve reports Bennett in Ohio in 1834 as the organizer and dean of the Willoughby Medical College. So the evidence is fairly conclusive this fraudulent institution did not last more than 12 months.

VINCENNES UNIVERSITY MEDICAL DEPARTMENT, 1837

Dr. Maple of Sullivan, Indiana, presents evidence that the Medical Department of Vincennes University was the first medical school established within our state.

Vincennes University, organized in 1806 while Indiana was still a territory, included in its charter provision for a medical department. For thirty years the difficulties of the school were such that the establishment of the medical department could not be undertaken.

On September 23, 1837, the University announced a medical faculty and courses of study and a few students were matriculated. The course was scheduled to begin the first Monday in December, 1837, and end the first Monday in March, 1838. Counting out Christmas vacation this would leave about a twelve-week course. The ticket for the course was eighty dollars, matriculation fee eight dollars, and dissection ticket five dollars. Difficulties of a serious nature arose, however, and it appears this effort to found a medical college lasted only one term.

LAPORTE UNIVERSITY SCHOOL OF MEDICINE, 1841-1856

The beginning of medical education in Indiana properly dates from the founding of the LaPorte University School of Medicine in 1841.

LaPorte University had been organized in the preceding year, 1840, the moving spirit being John B. Niles, A.B. and M.A., Dartmouth College. Though the medical school was organized in 1841, lectures were first given in 1843. In 1846 the name was changed to the Indiana Medical College.

The college had grown in enrollment to such a degree and the future prospects were so bright that in 1847 a special medical building was erected. In the spring of 1848, twenty-seven men were graduated. Sick people came from places as far as one hundred miles distant for treatment by members of the faculty. In the session 1848-1849, more than one hundred medical students were enrolled.

In 1851 there was announced a "consolidation" with the Indiana Central Medical College, organized in 1850 in Indianapolis as the Medical Department of Asbury University, later DePauw. The school owned a much prized microscope, charts, museum specimens and other equipment of value in medical instruction. In 1856 their main medical building, of which they were justly proud, burned with all its equipment. A group of fine and able men had been associated with the school, some of whom at a later period held staff appointments on the medical faculties of the University of Michigan and the University of Iowa.

This was an initial effort in medical education in every respect highly creditable and one in which Hoosiers in general and the medical profession in particular may take just pride. The destruction of the building and equipment was a grievous loss from which, due perhaps in part to dissensions which had arisen, they never recovered. The Indiana Central Medical College with which the Indiana Medical College of LaPorte had been "consolidated" had become extinct two years earlier, 1854.

Fortunately two annual announcements of the LaPorte University School of Medicine, 1847-48 and 1848-49, are found in the Indiana State Library, Indianapolis. There is also in the State Library a general announcement of LaPorte University for 1844-45.

This publication of LaPorte University for 1844-45 carries an announcement of the faculty for the fourth annual session of the School of Medicine as follows:

Daniel Meeker, M.D., LaPorte, Professor of Surgery and Surgical Anatomy.

John B. Niles, A.M., LaPorte, Professor of Chemistry. George W. Richards, M.D., St. Charles, Illinois, Professor of Anatomy and Physiology.

M. L. Knapp, M.D., Chicago, Illinois, Professor of Materia Medica.

Azariah B. Shipman, M.D., Courtlandville, New York, Adjunct Professor of Anatomy and Physiology.

Nichols Hard, M. D., Aurora, Illinois, Professor of Obstetrics and Diseases of Women and Children.

David E. Brown, M.D., Kalamazoo, Michigan, Professor of Theory and Practice of Medicine.

The announcement of the fifth annual session of the LaPorte University Medical School, 1845-46, states that the course of lectures would commence on the first Monday in November and would continue for sixteen weeks. There is an announcement of the establishment of a chair of Institutes of Medicine and Pathology to which Professor Richards was appointed. The fees for the course of sixteen weeks were sixty dollars. The requirements for graduation were:

First—The candidate must be twenty-one years of age. Second—He must be of good moral character.

Third—He must have spent three years in the study of medicine and must have attended two full courses of lectures, the last of which must have been in the LaPorte University School of Medicine.

Fourth—He was required to write a dissertation on some topic connected with the science of medicine.

The announcement further states that of the forty-five students enrolled,

- 18 were from Indiana
- 15 were from Illinois
- 6 were from Michigan
- 2 were from Ohio
- 2 were from New York
- 1 was from Virginia
- 1 was from England

This is surprising evidence of how widely this school was known. Dr. A. R. Barnes of the Mayo clinic states that William Worrall Mayo, father of the Mayo brothers, received his degree of Doctor of Medicine in 1850 from the LaPorte University School of Medicine. Dr. Eleazer Deming, of Lafayette, Indiana, had been his preceptor. He was assistant to Doctor Deming from 1850 to 1852. During part of that time he lectured at the college in LaPorte. Doctor Barnes further states that records show that William Worrall Mayo was admitted to membership in the Indiana State Medical Society in 1853. In 1854 he left for Minnesota.

The father of the late W. N. Wishard was also a graduate of this school.

THE MEDICAL COLLEGE OF EVANSVILLE, 1849-1854, 1871-1884

A detailed statement of the organization of the Medical College of Evansville is found in the *History of Vanderburgh County*, Brant and Fuller (1889). The statement was furnished by Dr. Madison J. Bray, when 78 years of age and Professor Emeritus of Surgery. He was a pioneer surgeon

¹ This "consolidation" ended in 1854 with the closing of the Indiana Central Medical College.

and one of the founders of the school. The school was organized in the office of Doctors Trafton and Weever in Evansville on the evening of March 1, 1846. The charter was not secured until 1847. The first course of lectures of the college began Monday, November 5, 1849. The first class was composed of forty-one matriculates, nine of whom were candidates for graduation. The course, three months long, consisted of five lectures per day, with the exception of Saturday when but two lectures were given.

The first Commencement was held in the Methodist Church on the evening of Saturday, February 23, 1850. There was an address by Judge C. I. Battell, president of the Board of Trustees, and also an address by James E. Blythe, a prominent attorney. Classes were graduated in 1850, 1851, 1852, 1853 and 1854. The lectures to the classes terminated in 1854 and were not resumed until in 1871. They continued until 1884 when the school closed.

THE INDIANA CENTRAL MEDICAL COLLEGE INDIANAPOLIS, 1849-1852²

The Indiana Central Medical College was organized in Indianapolis as the Medical Department of Indiana Asbury University (now DePauw) in 1848, too late to make a beginning of instruction in the 1848-49 session. The first session opened on the first Monday in November 1849, as scheduled in the Catalogue of Asbury University for 1848.

The Day Book of Asbury University states, under date July 9, 1852 that "the Medical School was suspended for lack of funds." A course was advertised to begin on the first Monday of November 1852, but the Day Book would indicate that this session was never held.

In 1851 a consolidation had been made with the LaPorte University School of Medicine. Publications of the LaPorte school state that this "consolidation" ended in 1854 with the closing of the Indiana Central Medical College. This statement has led to the erroneous conclusion that the Indiana Central Medical College closed in 1854. The correct conclusion must be that the LaPorte school did not trouble to dissolve this consolidation of 1851 until two years after the Indiana Central Medical College had expired.

² Since confusion has existed regarding dates of opening and closing of the Indiana Central Medical College, I repeat I have followed records of Catalogues and Day Book of the Indiana Asbury University in the above statement in favor of which there is much additional evidence. Perhaps the best of the evidence supporting the dates 1849-52, is found in editorials on Dr. John Bobbs, dean of this school, found in the *Indianapolis Sentinel* and the *Indianapolis Journal* May 2, 1870, following his death on May 1, 1870.

THE INDIANA MEDICAL COLLEGE INDIANAPOLIS, 1869-1878

The Indiana Medical College, Indianapolis, was organized in 1869. In 1871 this school became the Medical Department of Indiana University. This affiliation, which was not free from difficulties, was terminated in 1876 by mutual consent. Classes of the Indiana Medical College were graduated from 1870 to 1878 when it united with the College of Physicians and Surgeons of Indiana to form the Medical College of Indiana.

In the legislative Act of February 15, 1838, whereby Indiana College was given the name and style of the Indiana University it was specified that in addition to arts and science courses, instruction should be given in Law and Medicine. Steps were taken at once looking to the selection of a professor of Law, and in 1842 David McDonald was elected to this position. The establishment of a School of Medicine was, however, a far more difficult matter. The budget of the University was very small, consisting of the interest on seventy-some thousand dollars derived from the sale of a grant by the federal government of two townships of land, plus small fees paid by a few hundred students.

It was not until 1871 that the possibility was presented of complying with the mandate of the Legislature to give instruction in medicine, by making an affiliation with the Indiana Medical College.

In the Indiana University catalogue for the academic year 1869-70, we find under the title, "The Conditions and Wants of the University," the following sentence: "In the professional departments should be established, that of medicine. A first class medical college should be provided, connected with the University, in which tuition shall be free for all."

This objective is repeated in the 1870-71 catalogue.

Then in the 1871-72 catalogue of Indiana University, we find the announcement of the Medical Department for the following year, 1872-73.

- G. W. Mears, M.D.,
Professor of Obstetrics
- H. W. Wiley, M.D.,
Professor of General Chemistry
- J. A. Cominger, M.D.,
Professor of Surgery
- R. N. Todd, M.D.,
Professor of Principles and Practice of Medicine
- T. B. Harvey, M.D.,
Professor of Medical and Surgical Diseases of Women and Diseases of Children
- L. D. Waterman, M.D.,³
Professor of Anatomy and Clinical Surgery

³ Luther Dana Waterman came into the Indiana University faculty again in 1908 as Emeritus Professor of Medicine, and in 1915 established at Indiana University the Waterman Foundation for Scientific Research.

W. B. Fletcher, M.D.,

Professor of Physiology

Thad. M. Stevens, M.D.,

Professor of Medical Jurisprudence, Toxicology, and Analytical Chemistry

Dougan Clark, M.D.,

Professor of Materia Medica and Therapeutics

C. D. Wright, M.D.,

Lecturer on Diseases of the Eye and Ear

S. C. Tomlinson, M.D.,

Demonstrator of Anatomy

It should be noted there was no professor of Pathology.

No announcement of the Medical Department is made in the University catalogue of 1876-77. The connection of Indiana University with the Indiana Medical College was terminated in 1876 by mutual consent.

At Indiana University in 1875 the progressive administration of Cyrus Nutt was terminated. His successor, President Lemuel Moss, was much disturbed by the low requirements for entrance in professional schools.

In his report to the Board of Trustees of Indiana University under date December 23, 1876, printed in full in the University catalogue for 1876-77, President Moss wrote:

"It may not be practicable for you at once to require the degree of preparation I have indicated as the condition of admission to a professional school, but surely some requirement may be made, so that persons who would fail in an examination for entrance into an ordinary grammar school may not readily pass, under the patronage of the State, to the study of medicine or law. I would recommend, as the minimum requisition, to be increased as soon as practicable, that any person who wishes to enter any professional school which is or may hereafter be under the control of your board, should pass a preliminary examination equivalent to that required for entrance into the Junior Class in College."

President Moss was right in considering entrance requirements shamefully low. It was not until 1903 that with the organization of the Indiana University School of Medicine two years of collegiate work were required for entrance, and it was fifteen years later before that requirement was generally adopted.

THE PHYSIO-MEDICAL COLLEGE OF INDIANA INDIANAPOLIS, 1873-1909

The Physio-Medical College of Indiana was organized in Indianapolis in 1873. The first class was graduated in 1874 and a class was graduated each subsequent year, including 1909, when it became extinct. Its existence for a period of thirty-six years entitles it to the record as the school longest in existence under its incorporated title of any of the many early medical schools of Indiana. On the closing of this school, some of its students who met entrance requirements were admitted to the Indiana University School of Medicine, and members of the

faculty of this school were granted the privilege of lecturing on the particular theories of their school to any students of the Indiana University School of Medicine who might elect to hear such lectures. Since no students enrolled for these courses, they were never given.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF INDIANA INDIANAPOLIS, 1873-1878

The College of Physicians and Surgeons of Indiana was organized in 1873 in Indianapolis. A class was graduated each year from 1874 to and including 1878, when it joined Indiana Medical College (see above) to form the Medical College of Indiana.

THE MEDICAL COLLEGE OF FORT WAYNE 1876-1883

The Medical College of Fort Wayne was organized in 1876. Classes were graduated from 1877 to 1883, when it became extinct.

THE MEDICAL COLLEGE OF INDIANA INDIANAPOLIS, 1878-1905

The Medical College of Indiana, mentioned twice above, was organized in Indianapolis in 1878 by the union of the Indiana Medical College and the College of Physicians and Surgeons of Indiana. The first class was graduated in 1879 and a class was graduated each subsequent year including 1905. It was the Medical Department of Butler University from 1879 to 1883, but continued to retain the name, Medical College of Indiana. In 1895 the Medical College of Indiana became the Medical Department of the University of Indianapolis. In September of 1905 it merged with the Central College of Physicians and Surgeons, Indianapolis, and the Fort Wayne Medical College to form the Indiana Medical College, School of Medicine of Purdue University. In April, 1908, this merged Indiana Medical College was united with the Indiana University School of Medicine, under the name of the latter.

Although there were these mergers with change of name, and other lighter affiliations, there was essential continuity in control and management of the Indiana Medical College and the Medical College of Indiana from 1869 to 1908, when the school was absorbed by the Indiana University School of Medicine. Though new blood was introduced from time to time through successive unions, the faculty leaders of the Indiana Medical College in 1908 were the natural successors of the faculty of the Indiana Medical College of 1869-78. They were for the greater part the young instructors of earlier years who with maturity had come into positions of major responsibility. The dean of the Indiana Medical College of 1908, Dr. Henry Jameson, had been an assistant professor in the Indiana Medical College in 1872 when it was the Medical Department of Indiana University.

In the sense of continuity of leadership, this school, despite changes in name, may be regarded as having had an existence of 39 years, extending from its organization in 1869 as the Indiana Medical College to its final absorption as an integral part of the Indiana University School of Medicine in 1908.

We learn from the announcement of the Medical College of Indiana for 1894-95 found in the Indiana University Library that the school occupied a building at the corner of Maryland and Pennsylvania Streets.

For entrance to the school the student was required to pass, at the college, a creditable examination "in the manner prescribed by the Illinois State Board of Health, which requires an elementary knowledge of the principles of physics, of good English, and of mathematics as taught in our public schools."

"Graduates of a literary or scientific college, academy or high school . . . will be exempt from this examination.

"Graduates of reputable Dental Colleges who can submit evidence of attendance upon lectures in Materia Medica, Chemistry and Oral Surgery, graduates in good standing from a regular college of Pharmacy, and students who have taken the prescribed preliminary courses at any university . . . will be admitted to our Senior Course on the completion of one course of lectures at this college."

This meant that these groups of students referred to above could complete the medical course in the Medical College of Indiana in two years.

Under requirements for graduation we find enumerated:

1. Satisfactory evidence of a good moral character.
2. Must have attained the age of twenty-one years.
3. Must file a satisfactory certificate of having studied medicine for at least four years under a regular graduate, or licentiate or practitioner of medicine.
4. During the four years of medical study cited in "3," he must have attended three full sessions of instruction of six months each in some medical college, "the last of which shall be in this college," i.e., the Medical College of Indiana.

There were other requirements such as paying all fees, etc. Total fees for the three year course amounted to \$230.

The three year course of study is interesting in that it did not present what we now regard as a logical sequence of subjects. The first semester's work consisted of Gross Anatomy, Materia Medica, Principles of Surgery, and General Pathology. Bacteriology is scheduled in the last semester of this three year course of study, which indicates a lack of appreciation of the importance of this subject, in spite of the rather impressive departmental announcement.

A new home for the Medical College of Indiana was erected in 1895 at the corner of Market Street and North Senate Avenue.

The four year course of study effective for students graduating in 1899 and thereafter, shows some improvement over earlier announcements. Bacteriology is placed in the second year. Except for minor surgery there is no clinical work in the freshman year, but in the sophomore year Gynecology, Principles of Medicine, Principles of Surgery, and Physical Diagnosis are scheduled with clinics in Medicine and Surgery.

The establishment by the Legislature of 1897 of the Indiana State Board of Medical Registration and Examination was a very important event in the advancement of standards of medical education in Indiana. Prior to that time a medical school might wish to raise requirements for entrance and graduation, but it had no power to enforce its worthy objective on other schools. There were five medical schools in Indiana and a dozen or more just across state lines. Refused in one school, the applicant for admission cheerfully gravitated to some near by school which set a less rigorous examination.

Dr. Henry Jameson succeeded Dr. Joseph W. Marsee as dean of the Medical College of Indiana, in 1899.

THE INDIANA COLLEGE OF MEDICINE AND MIDWIFERY INDIANAPOLIS, 1878-1888

The Indiana College of Medicine and Midwifery, Indianapolis, was organized in 1878 by one Charles P. Heil. Extinct about 1888.

THE CENTRAL COLLEGE OF PHYSICIANS AND SURGEONS INDIANAPOLIS, 1879-1905

The Central College of Physicians and Surgeons was organized in Indianapolis in 1879. The first class was graduated in 1880 and a class was graduated each subsequent year until 1905, when it merged with the Fort Wayne College of Medicine and the Medical College of Indiana to form the Indiana Medical College, School of Medicine of Purdue University, which in April, 1908, was united with the Indiana University School of Medicine. It existed for twenty-six years.

It was really the reorganized College of Physicians and Surgeons of 1873-78. The union of this school with the Indiana Medical College, like all such unions, involved certain inherent and inescapable difficulties. The two old schools with their faculties had been rivals, and rivalries were not ended by the union. The problem of rank or title might be hurdled by giving faculty members of each department of the old schools their respective titles in the united school. The real difficulty was encountered, however, in allocation of teaching duties (or privileges); for in the united school there were two rival aspirants for each teaching position.

Men had favorite courses which they were unwilling to give up or divide. So a union of schools could be far from complete and could easily set the stage for early reorganization of one or the other of the old schools.

This seems to have been the situation in organization of the strong Central College of Physicians and Surgeons. It was a definite and very progressive rival of the Medical College of Indiana, which, however, had the "silk hat and Prince Albert coat" faculty.

In the library of Indiana University are found copies of the First Annual Announcement of the Central College of Physicians and Surgeons, 1879-80, and of the Second Annual Announcement, 1880-1881, which is the catalogue for 1879 and '80.

The college was located at the northwest corner of Indiana Avenue and Senate Avenue. The first session began on the first day of October, 1879, and continued for twenty weeks. There were four to six lectures daily besides clinical instruction in the City Hospital, St. Vincent's Hospital, and the City Dispensary. There is a special notice that: "The degree of doctor of medicine will not be conferred on anyone who has not acquired the common elements of education, as arithmetic, elementary physics, English grammar, and composition."

A three year graded course of study was adopted as follows:

First Year: Anatomy (including dissection), Histology, Physiology, General Chemistry.

Second Year: Anatomy (practical and surgical), Medical Chemistry, Materia Medica and Therapeutics, Principles of Medicine, Minor Surgery, and Clinical Medicine and Surgery.

Third Year: Practice of Medicine, Obstetrics and Gynecology, Surgery, Ophthalmology and Otolaryngology, Clinical Medicine and Surgery.

It will be observed this course of study shows an appreciation of the logical sequence of subject matter.

The requirements for graduation were those adopted by the American Medical College Association which had been formed in 1876. The Articles of Confederation were printed in full in this bulletin of the Central College of Physicians and Surgeons. The requirements for graduation as stated in Article 3, provide that the candidate for graduation must have studied medicine for at least three years under a regular graduate, or licentiate and practitioner of medicine in good standing and that during those three years he must have attended two full courses in a medical school, the second of the two courses being in the college issuing the diploma.

This was the rule of the American Medical College Association and represented the thought of American Medical Colleges of seventy-five years ago.

The twenty-second annual announcement of the Central College of Physicians and Surgeons (1900-1901) outlines the following requirements for admission:

Orthography
English Grammar
English Composition
Geography
Rhetoric (Rules and uses of rhetorical figures)
Latin (one year)
Arithmetic
Algebra (through simple equations)
Physics (elements of mechanics, heat, electricity, optics, acoustics)
Botany (structure of plants and principles of classification)
United States History

This represents the completion of about one year of high school work.

Under the heading "Advanced Standing" we read:

"A credit, without examination, of one year, will be given to graduates of literary colleges whose course has included the natural sciences."

The course of study outlined covered four years. The arrangement of courses shows an appreciation of logical sequence of subject matter. There were no clinics in the first two years, a procedure followed very generally at a later period.

The school year began October 1, and ended April 25, and was about twenty-eight weeks in length.

The excellent new college building on North Senate Avenue, one-half block from the State House, was erected in 1902 and provided in a superior way for dispensary, lecture rooms, and laboratories. The laboratories were hygienic, well-lighted and well-ventilated. It was a building of which the school had every reason to be proud.

This new medical building was erected only seven years after the building of the Medical College of Indiana at the northwest corner of Senate and Market Streets. But those seven years were enough to catch and incorporate in the new building of the Central College of Physicians and Surgeons some of the rapid developments in medical education taking place in those years, which rendered the building much the better adapted to the new type of medical instruction.

Educationally the school had broken away from the almost purely didactic type of instruction of earlier years and now gave much time to laboratory work. In the freshman year, for instance, there were three lectures per week in Gross Anatomy and ten hours per week in Dissection, throughout the year.

Pathology and bacteriology laboratories were scheduled in the second semester of the sophomore year.

The school had a faculty of superior men, many of whom were long active in the Indiana University School of Medicine, contributing much to the leadership of our school.

THE FORT WAYNE COLLEGE OF MEDICINE FORT WAYNE, INDIANA, 1879-1905

The Fort Wayne College of Medicine, Fort Wayne, Indiana, was organized in 1879. The first class was graduated in 1880 and a class was graduated each subsequent year except 1899. After operating under its chartered name for twenty-six years, in 1905 it merged with the Medical College of Indiana and the Central College of Physicians and Surgeons to form the Indiana Medical College, School of Medicine of Purdue University. In April, 1908, this merged Indiana Medical College was united with the Indiana University School of Medicine, under the name of the latter.

The strength of this school lay in its clinical faculty. Doctors Porter, Duemling, McCaskey, Drayer and Bulson were widely recognized as among the best men of the state. They were ably supported by others, only a little less widely known. But with the coming of the requirement of full-time men in preclinical courses, such as Anatomy, Physiology, Pharmacology, Chemistry, Pathology, and Bacteriology, with their requirement of well-equipped laboratories, these men knew the day had dawned when a union of medical facilities and efforts in Indiana was necessary, and they were among the most vigorous advocates of measures to that end.

THE INDIANA ECLECTIC MEDICAL COLLEGE, INDIANAPOLIS, 1880-1890

The Indiana Eclectic Medical College, Indianapolis, was organized in 1880. The first class was graduated in 1881. It absorbed the Beach Medical Institute in 1886 and closed in 1890.

THE CURTIS PHYSIO-MEDICAL INSTITUTE MARION, INDIANA, 1881-1900

The Curtis Physio-Medical Institute, Marion, was incorporated in 1881. The first class was graduated in 1882. A new charter was obtained and the school was moved to Indianapolis, where classes were graduated in 1893 and 1894, when it returned to Marion. Extinct in 1900.

THE HOSPITAL MEDICAL COLLEGE EVANSVILLE, 1882-1886

The following statement of the organization of the Hospital Medical College was furnished by Dr. M. J. Bray in *History of Vanderburgh County, Indiana* (1889):

"HOSPITAL MEDICAL COLLEGE—The organization of this institution was due to the efforts of Dr. A. M. Owen. It was chartered in 1872.³ Its first faculty was composed as follows: Dr. George B. Walker, dean and professor of Obstetrics; Dr. A. M. Owen, professor of Surgery; Dr. Charles Knapp, professor of Theory and Practice of Med-

icine; Dr. C. M. Dudenhausen, professor of Materia Medica and Therapeutics; Dr. John E. Owen, professor of Anatomy; Dr. A. M. Scott, professor of Physiology; Dr. Edward Murphy, professor of Chemistry; Dr. W. D. Neal, professor of Diseases of Women; Dr. J. S. Gardner, dean of Anatomy. The college was so ably managed and its instructors were of such high standing in the profession that its success was remarkable. Degrees were conferred on nine graduates at the close of the first year, and in all about fifty physicians received . . . diplomas. The engrossing demands of Dr. Owen's practice forced his resignation, and principally because of faculty losses it was deemed best to suspend operations under the charter. The enterprise was highly successful and it is now the purpose of the friends of the old institution to revive it and again make Evansville the seat of a medical college which will be the pride of the state."

By good fortune the Society of Arts and History of Evansville has come into possession of the Minute Book and Catalogues of the Hospital Medical College of Evansville.

The Hospital Medical College was not the most important medical school of this period, 1878 to 1882, which marked the establishment of medical education in Indiana on a more substantial, more enduring basis. It will be recalled that the Medical College of Indiana was chartered in 1878 and that in the following year, 1879, the Central College of Physicians and Surgeons of Indianapolis and the Fort Wayne College of Medicine were organized. All three of these schools had an existence of more than a quarter century.

The Hospital Medical College was disbanded in 1886 and was never reopened.

During the twenty years following organization of the Hospital Medical College of Evansville, 1883 to but not including 1903, six medical schools were established in Indiana, five of which were located in Indianapolis and one in Valparaiso. Of the five schools organized in Indianapolis, three were eclectic. Since the Eclectic Medical College of Cincinnati was long established and strong, this medical sect was finding difficulty in establishing a school in Indianapolis. Two other schools of the five organized in Indianapolis during this period, the American Medical College and the University of Medicine, notwithstanding their pretentious titles, were remarkable only for the brevity of their existence.

The following is a brief account of these six schools.

THE BEACH MEDICAL COLLEGE, INDIANAPOLIS, 1883-1886

The Beach Medical College, Indianapolis, was organized in 1883. It became the Beach Medical Institute in 1884. It merged with the Indiana Eclectic Medical College in 1886. One class was graduated in 1885.

³ Surely a misprint, for the Secretary of State says Articles of Association were filed July 27, 1882.

THE ECLECTIC COLLEGE OF PHYSICIANS AND SURGEONS INDIANAPOLIS, 1890-1894

The Eclectic College of Physicians and Surgeons, of Indianapolis, was organized in 1890, after the Indiana Eclectic Medical college had closed. Classes were graduated from 1891 to 1894 inclusive. After an interval of six years when there was no eclectic medical college in Indiana, the Eclectic Medical College of Indiana was organized (see below).

THE AMERICAN MEDICAL COLLEGE OF INDIANAPOLIS, 1894-1897

The American Medical College, of Indianapolis, was organized in 1894. Classes were graduated in 1895, 1896, and 1897, when it became extinct.

THE UNIVERSITY OF MEDICINE, INDIANAPOLIS, 1897-1898

The University of Medicine was organized in 1897 in Indianapolis. A class was graduated in 1898, but there is no evidence that other classes were graduated. It is reported as not recognized by the Indiana State Board of Medical Examiners during its existence.

THE ECLECTIC MEDICAL COLLEGE OF INDIANAPOLIS, INDIANA 1900-1908

The Eclectic Medical College of Indiana was organized at Indianapolis in 1900. The first class was graduated in 1903. A class was graduated each subsequent year until 1908 when it suspended. After suspension, certain members of the faculty were given the privilege of lecturing on their particular medical theories to students of the Indiana University School of Medicine who elected to hear them. Since no students elected these courses they were not given.

VALPARAISO UNIVERSITY COLLEGE OF MEDICINE, 1901-1918; 1920-1922

The Valparaiso University College of Medicine differed from all other medical colleges organized in Indiana in that it was the only school located in two states, part in Indiana and part in Illinois, and the only school organized in Indiana which operated under the laws of another state, viz. Illinois.

Catalogues of Valparaiso College, as it was called at the beginning of this century, repeat the statement that medical work was started in 1901, i.e., the year 1901-02 was the first year of this school. The preliminary announcement made in the Catalogue of Valparaiso University in 1900 did not include courses in Bacteriology or Pathology and made no provision for clinical instruction. It read as follows:—

"Preparatory to a regular Lecture Course we have organized a Reading Course in Medicine. This gives all who desire to prepare for the medical profession the opportunity to do so at one fifth the usual expense. We

have all the apparatus and facilities for study of Anatomy, Physiology, Materia Medica and Chemistry that are found in any medical college."

It should be understood that in 1900 Valparaiso College had about 3,300 students. It was widely known as a school where an opportunity for an education was provided at a minimum cost. Many were attracted by the opportunity of taking all the courses they could carry. The president, Henry B. Brown, was an extraordinarily able organizer and administrator who in 1901 saw an opportunity of expanding the few medical courses offered at Valparaiso into a full four year medical course.

In nearby Chicago there had been organized in 1901 the American College of Medicine and Surgery (Chicago Eclectic Medical College) located at 333 South Lincoln Street, near Cook County Hospital. During the year 1901-02 arrangements were consummated whereby this school became the Medical Department of Valparaiso University. The work of the first two years of the four year course could be taken either at Valparaiso University or in Chicago. The last two clinical years were given in Chicago only. Valparaiso University announced it would confer the degree Doctor of Medicine on all who completed the course.

This Valparaiso University Medical College opened its first session on October 15, 1902. A later catalogue stated that more than 150 students were registered during the first year. The title of the Chicago division of the school was retained except that the parenthesis, (Chicago Eclectic Medical College), was dropped. In 1905 eclecticism was dropped, and in 1907 the title of the Chicago division of the school was changed to Chicago College of Medicine and Surgery. The total registration in 1907-08 was 325.

The catalogue of Valparaiso University for 1907 stated that "owing to the fact that all students of the college of medicine are required to finish their course in Chicago the department operates under the laws of the State of Illinois and complies with all requirements of the Illinois State Board of Health." It was also announced that Valparaiso University had taken over the building of the Chicago College of Medicine and Surgery.

For a time the Valparaiso University School of Medicine profited by other medical educational developments of the state of Indiana, and by its operation under Illinois laws.

In 1908, following union of the old medical schools of the state with the Indiana University School of Medicine, announcement was made of an increase in entrance requirements to two years of collegiate work. This requirement became effective in 1910-11 for students entering the Indiana University School of Medicine, and was adopted in January 1911 by the Indiana State Board of Medical Registration and Examination for all schools whose graduates sought license in Indiana. It was not until the school year beginning September 16, 1913 that the Valparaiso school required one year of collegiate work for entrance. In the year 1912-13 nearly 600 medical students were listed.

1917 was however a calamitous year for the Valparaiso University College of Medicine. The Bennett Medical College of Chicago, by affiliation, in 1910 had become the Medical Department of Loyola University. In 1915 it became an integral part of Loyola University, which assumed full control of the school. In 1917 this Bennett Medical College took over by purchase, and assumed the name of the Chicago College of Medicine and Surgery.

On September 16, 1917 Henry B. Brown, president of Valparaiso University, died.

The clinical years of the medical college were discontinued. During the year 1917-18 the work of the freshman and sophomore years was taught at Valparaiso University; but this work also was discontinued at the end of that school year. The catalogue for 1918-19 carried the announcement that "during the year 1918-19 and until further notice, the University will not give medical work."

In 1920 an effort was made to revive the medical school by an educational affiliation with the Hahnemann Medical College of Chicago, which became the Medical Department of Valparaiso without losing its separate organization as a medical school. Two years of collegiate work in addition to a four year high school course were required for admission.

This announcement was repeated in the bulletin of the University for 1921-22 printed in September 1921. But the day had passed when new sectarian medical schools could be launched successfully and with the close of the year 1921-22 all medical courses at Valparaiso University were discontinued.

ADVANCEMENT IN MEDICAL KNOWLEDGE

Medical knowledge increased in the last half of the 19th century more than it had in the preceding 18 centuries.

The last half of the 19th century began with the average life rate about two years longer than at the beginning of the Christian era. Infant mortality was appalling. There was a mortality of 80% in amputations. Surgeons passed from the dissecting room to the operating room. In the Hotel Dieu (the City Hospital) in Paris old bedding was used for surgical dressings, and in winter time the nurses broke the ice in the Seine to do hospital washing. The city abattoir was in the basement of the hospital. In London nurses slept on a bit of straw under the stairs. In Philadelphia at Blockley Hospital they had the ten day nurse; i.e., a woman drunk and disorderly was sent to the hospital to work out her time.

It is true that anesthetics, chloroform and ether, had been introduced 1846-47, and the great pioneer work of Ephraim McDowell, 1809, in opening the abdomen surgically was attracting more and more doctors to the developing field of abdominal surgery. Yet there was little to suggest that the stage was being set for a revolutionary advance in medical knowledge, unless one knew of, and could

properly evaluate, the work of a few obscure men of science who were studying microorganisms.

The existence of microorganisms was known prior to the 19th century and they had been suspected by a few men of science as causing disease.⁴ But it was not until about 1865 Davaine showed that by injection of *Anthrax bacilli* (described about 15 years earlier) into a healthy sheep or cow, the disease Anthrax could be produced. A decade later Pasteur showed how the microorganisms of Anthrax and Chicken Cholera could be attenuated, and how, by injection of these weakened organisms, an artificial immunity could be induced. Pasteur laid down the principles of antiseptic surgery, recognized as sound and put in practice by Lord Lister in London, and later improved as aseptic surgery, thus opening the great field of modern surgery. In 1882 Koch demonstrated the tubercle bacillus as the cause of tuberculosis. Microbe hunters developed in every civilized country of the globe and bacteriology was established as a science to be included in the curriculum of every progressive school of medicine.

Definite changes in body tissues came to be recognized as occurring in certain diseases. Autopsy findings came to be associated with certain clinical symptoms. Abnormal anatomy or Pathology grew in importance and called for more and more time in the medical curriculum and for a special laboratory and equipment.

Knowing the cause of various infectious diseases and how they were transmitted, it was possible to develop procedures for avoiding many diseases, thus preventive medicine was launched on its expanding career, which today has become the Department of Public Health.

In the last half of the 19th century the field of definite medical knowledge doubled. Under pressure of this new medical knowledge a general demand was created for a medical course of 4 years of nine months each. Even with this increase in time the medical course grew crowded, and what was false or useless was crowded out to give time for the new and proven. *Materia Medica* to which much time had been devoted in recognition of flower, leaf, bark and root, with the making of their various tinctures, extracts, etc., gave way to pharmacodynamics in which the physiological action of the drug was studied in the laboratory. It came to be recognized that nothing was known of the potency of the herbs the doctor had in his office, so pharmaceutical establishments arose in which potency was tested and dependable preparations were made.

At the beginning of this century it was recognized that with the enormous increase in the importance of preclinical subjects extensive laboratories with costly equipment and manned by full

⁴In his introductory lecture in Surgery in the La-Porte University School of Medicine in 1847, Dr. A. B. Shipman said: "Epidemic diseases have by many writers, been conjectured to originate from this source (microscopic animalculae)."

time men were necessary in a medical school. This greatly increased the cost of medical education. Where were the funds to be found for this new medical education? The strength of medical schools, integral parts of State Universities or well-endowed Universities, was recognized as the answer. So the 165 medical schools of the United States began seeking University connections.

It was soon realized that Universities could expend funds only on educational projects under their complete control, that nothing short of a union in which the medical school surrendered to the University its name, its plant and full control of the school as an integral part of the University could make possible the necessary financial support.

This was the situation in medical education at the beginning of this century when Indiana University decided she could and should establish a school of medicine, as authorized in the act of 1838. But there were certain collateral developments, partly state and partly national, in the last half of the 19th century which were of major importance in the development of medical education in Indiana. The state developments included legislative establishment of:

1. A State Anatomical Board.
2. Requirements for license to practice medicine and surgery.
3. A State Board of Medical Registration and Examination.

National developments included the organization of the Association of American Medical Colleges; and the appointment of the Council on Medical Education of the American Medical Association.

These agencies, each in its own way, made an important contribution to the advancement of medical education by raising requirements for practice of medicine and surgery; by providing an adequate supply of cadavers for instruction in Anatomy; by raising qualification requirements for entrance on the study of medicine; by establishing standards of time, course, and equipment of acceptable medical schools, etc.

THE STATE ANATOMICAL BOARD

The earliest acts relating to human dissection are found in the penal code. Their purpose was not provision of bodies for dissection, but the establishment of punishment to be imposed upon anyone found with a body in his possession for the purpose of dissection, without consent of relatives.

Chapter 5 of the Acts of the second session of the Indiana General Assembly, 1817-18, deals with "Crimes and Punishment." Section 21 reads as follows:

"If any person or persons shall remove the body or corpse of any person interred in any burying ground, either public or private, for the purpose of dissection or any other purpose unauthorized by law, he or they shall be deemed guilty of a high misdemeanor, and upon conviction thereof, shall be fined in any sum not exceeding one thousand dollars; Provided, that nothing herein contained, shall be so construed as to prevent any relative

of the deceased from taking up the body of said deceased for the purpose of reinterment in any other place, or for dissection."

Since relatives were often difficult to locate and their consent to disinterment rarely secured, this act gave very little help to medical schools in procurement of bodies for dissection.

In 1879 the State Legislature passed an Act entitled:

AN ACT to promote the science of medicine and surgery, by providing methods whereby human subjects, for anatomical and scientific dissection and experiment, may be lawfully obtained, and prescribing penalties for violation thereof.

The preamble of this Act and the first section read as follows:

"WHEREAS, The public welfare demands the highest knowledge and scientific skill in members of the profession of medicine and surgery, and, to this end, that means be by law provided whereby proper subjects for anatomical and scientific dissection and experiment may be obtained for the use of colleges duly organized for instruction in medicine and surgery; therefore,

SECTION 1. *Be it enacted by the General Assembly of the State of Indiana*, That when the body of any person who shall die in any state, city or county prison, or jail, or county asylum or infirmary, or public hospital, within this State, shall remain unclaimed, by any next of kin or relative of such deceased person, for twenty-four hours after death, and be liable to be buried at public expense, and there are no next of kin of such deceased person, or next of kin, if known, shall, upon notice, refuse to receive and bury the body of such deceased person, such body may be used as a subject for anatomical dissection and scientific examination, in aid of medical and surgical science, as hereinafter prescribed: *Provided*, That when any person shall express a wish to be buried, the dead body of such person shall not be delivered for dissection, but shall be properly buried."

It will be noted the bodies to be delivered to medical institutions were such as were "*liable to be buried at public expense.*" Section 3 emphasizes that certain bodies were not to be delivered to medical institutions for dissection "*except upon the neglect or refusal of such next of kin, after due notice, to receive and bury, or pay for the burial of such body.*"

It was provided that the medical school should keep a record book in which should be entered the name, sex, age, residence, cause of death, and date of death of such unclaimed person.

Section 4 provided that the bodies of convicts executed under the laws of the state, *might be* delivered to a medical school if not claimed by relatives. Section 5 referred to vagrants found dead, to persons killed while committing a felony, and convicts killed in an attempt to escape, who, if not claimed by next of kin, *might be turned over to a medical school, at the discretion of the officer in charge, with the approval of the county sheriff.*

The sections in which action was permissive instead of mandatory, the section in which action was at the discretion of an officer in charge, greatly weakened the effect of the law. Even if the officer in charge were in sympathy with the law, and many were not, the difficulty of notifying relatives, in a day when there were no telephones,

was so great that much more time than the 24 hour limit was frequently necessary, and in a day of imperfect or no embalming, decomposition often rendered the body next to useless for dissection. As a student of medicine in New York State in 1898, embalming having been so poor, and refrigeration so inadequate, I rarely saw nerves smaller than the lead of a pencil. Here in Indiana in the years when this Act was in effect, 12 to 15 students worked on a cadaver, racing to learn all they could before decomposition claimed the body.

After nearly a quarter century under this law, and a few near scandals, the present anatomical law was adopted and approved February 25, 1903. This new law created a State Anatomical Board as a responsible single agency to which bodies not claimed by relatives for burial, were reported, and by which they were distributed to medical schools in proportion to the number of students registered.⁵ This Anatomical Board kept records as specified in the law of 1879 and repeated in the law of 1903. For a third of a century under this law an adequate supply of well-embalmed bodies was available for the training of the future doctors of medicine. For a third of a century, Sec. 2 of this Act, reading thus: "It shall be the duty of every public officer . . . having in his possession the dead body of any person not claimed by any relative or legal representative . . . and which may be required to be buried at public expense or the expense of any one of such public institutions," was interpreted by the Attorney-General of Indiana as meaning that if relatives claimed the body, burial was at the expense of claimants.

Then in the administration of Governor Townsend the Attorney General handed down a decision that relatives, under this law could *claim the body for burial at public expense*. Then came social security in which individuals dying in certain institutions, were buried under social security, at public expense.

This decision and this social agency materially reduced the number of bodies available for dissection. We have here two social interests in conflict, both commendable, (1) the public interest in providing bodies for dissection, (2) the humanitarian interest in providing burial for unfortunates.

Every citizen is supposed to contribute something to the welfare of the state. The only contribution these unfortunates can make is to supply their bodies for the training of medical men who give their lives to the protection of life and health of Indiana citizens. When Hoosier people get a square look at this problem, they will recognize the superior claim of general public interest in bodies for dissection, and will restore the adequate supply needed for training successive generations of able doctors of medicine.

Since 1903, that is for more than forty years, the record book of the State Anatomical Board has

been faithfully kept. Details of name, age, sex, color, residence, cause of death, date of death, undertaker in charge, etc. are recorded. Bodies are given a second embalming at the school of medicine which preserves them indefinitely. Normally bodies are not taken to the dissecting room in less than six months after they are received. Every year or two bodies, long after being received, are claimed by relatives who were not known or could not be reached at the time of death. In such cases the bodies are delivered to properly certified claimants, and delivered perfectly embalmed, if they were in good condition when received. No embalming can restore decomposed tissues to normal.

When dissection is complete the remains are incinerated in a mortuary incinerator. In a few cases when requested, the ashes from such incineration have been placed in a glass container and delivered to relatives.

ORGANIZATION OF THE INDIANA UNIVERSITY SCHOOL OF MEDICINE

The story of the developments in medical education in Indiana which began in 1903, is a vital part of the history of Indiana University during the William Lowe Bryan administration, 1902-1937. In June 1902 Doctor Bryan was chosen unanimously by the trustees of Indiana University to succeed Joseph Swain as president. Following his graduation from the University in 1884 he had been continuously a member of the teaching staff of the University. From 1893 to 1902 he had been vice president of the University. He knew the institution as a student and as a teacher. He came to the presidency at the age of 42 with the conviction that the educational opportunities of the University should be increased by organization of additional professional schools.

"What the people need and demand is that their children shall have a chance—as good a chance as any other children in the world—to make the most of themselves, to rise in any and every occupation, including those occupations which require the most thorough training. What people want is open paths from every corner of the state, through the schools, to the highest and best things which men can achieve. To make such paths, to make them open to the poorest and lead to the highest, is the mission of democracy." This paragraph might well be called the platform of the new president.

Reports had been prepared by committees to determine what additions to the faculty would be necessary for establishment of each of a number of different schools. These studies showed that establishment of a School of Engineering seemed to offer the least difficulty. This possibility was rejected, however, since it would have duplicated work done at Purdue.

At the meeting of the Board of Trustees in March 1903, the president was prepared to report as follows:

⁵ Under the law of 1879 the body was delivered if at all, to the school that first claimed it, which made possible great inequality of distribution.

"I invite the attention of the Board to the question of establishment of a Medical Department in connection with the University. Following are the principal facts of the situation.

1. There is a general change in Medical and Legal Education, from schools owned and conducted by city practitioners to endowed schools whose teachers devote their whole time to instruction. In the best cases the medical school is not an independent institution affiliated with the university, but is an integral part of the university.

2. In all the better medical schools the course of study requires four years. The first two years work, however, is made up of subjects which are also taught in the science departments of the universities. It has been found, accordingly, that these first two years of the medical course can be done more economically, and also more satisfactorily, in the Departments of Zoology, Chemistry, Botany, Physics, Physiology, etc., than in connection with the medical school proper. At Chicago University, Northwestern University and the University of Illinois—to name our nearest neighbors—this arrangement is in force and is proving highly satisfactory.

3. For several years we have offered a number of medical courses. A student desiring these courses could take Chemistry, or Zoology as a major and could take as part of his college course enough elementary medical subjects to receive a little more than one year's advanced standing in the best medical schools.

4. In order to fill our two years work we should have to add human anatomy and pathology and we should have to increase very considerably the amount of work offered in Physiology.

5. It is my opinion that we should, if possible, establish the medical department at once, even if we cannot equip it adequately with men and means the first year."

Before presenting the report of the president at the June 1903 meeting of the Board of Trustees, it will be well to review the fact that many leaders in medical education had been observing with growing concern those changes in medical education calling for addition of new laboratory courses to the medical curriculum, requiring expensive equipment and specially trained full time teachers, thus adding to the cost of medical education which was mounting with alarming rapidity. It was becoming apparent to keen observers that only those medical schools which were integral parts of state or highly endowed universities would be able to survive and meet the rising cost of the trend in medical education. While the rush to become an integral part of a state or well-endowed university had not yet begun, farsighted leaders in medical education were canvassing the situation with such union in view.

At Commencement in June, 1903, the president was ready to report to the Board of Trustees what would be necessary to establish, at Bloomington, for the work of the freshman year of the medical course. The trustees voted in favor of the project and authorized that an invitation be extended to B. D. Myers, M.D., a member of the anatomy staff of Franklin P. Mall, at Hopkins, to visit the Bloomington campus for a conference. Following the conference Doctor Myers was offered an appointment, which he accepted on July 2, 1903.

On June 19, 1903 the president reported to the Board of Trustees that he and Mr. Fesler had met a committee from the Central College of Physicians and Surgeons to hear their proposal for an amalgamation with the University, and that this committee was present for a conference with the Board. He stated further that he had received a letter from Dr. Henry Jameson, dean of the Medical College of Indiana, proposing an interview upon the interests of medical education in Indiana. Dr. Jameson expressed himself as strongly in favor of an amalgamation of the two medical schools here mentioned, with Indiana University. The president believed that amalgamation of these two schools with the University would be to the interest of all concerned. However, no amalgamation was effected at that time.

INDIANA UNIVERSITY SCHOOL OF MEDICINE

1903 to September 1905

In November 1903 President Bryan reported to the Board of Trustees on the work of the freshman year of the Indiana University School of Medicine, and made recommendations for the organization of the work of the sophomore year of the School of Medicine. These recommendations included organization of a laboratory for Pathology and Bacteriology and appointment of an assistant professor to take charge of that work; appointment of an assistant to Professor Moenkhaus to take charge of Pharmacology; and appointment of an assistant professor of Anatomy, all appointees to be Doctors of Medicine. Laboratory quarters and equipment for Physiology and enlarged quarters and additional equipment for Microscopic Anatomy were to be provided.

The necessity for securing a supply of cadavers for dissection and of making contacts whereby students who completed the work of the two pre-clinical years at the Indiana University School of Medicine, might begin the work of the two clinical years of four year medical schools without loss of time, were matters also discussed at the November 1903 meeting of the Board of Trustees. Matters were progressing rapidly.

At the meeting of the Board of Trustees on March 28, 1904, the president presented to the Board the formal proposal of the Medical College of Indiana to become an integral part of Indiana University. It was the president's opinion that

two conditions should be established if the proposition were to be accepted:

1. Unhampered ownership and control should be vested in the University.

2. The first two years' work should be maintained at Bloomington.

Councils were divided. Many thought the whole school should be established at Bloomington, as at Michigan. Today with Bloomington a city of 25,000 and with excellent roads, such a plan would be feasible. But with Bloomington a small place of 4,000, with poor roads, and automobiles not regarded as yet as important means of general transportation, there were very great objections to this procedure.

Others would have had the whole school at Indianapolis in which case the tendency for it to become autonomous would have been very great.

The president concluded:

"I propose a wholly different plan. I propose two years work at Bloomington and two years work at Indianapolis, and I propose that in the immediate future, the strength of the University shall go toward making both as strong as possible.

"The Bloomington end of the problem is already solved. The Indianapolis end of it is far from being so. The great medical schools are lavishing money upon their clinical work and are furnishing facilities out of all comparison with those which can be offered at present at Indianapolis by any school or combination of schools. * * * We cannot avert the outcome simply by organizing in a new way, by giving our name to a school in Indianapolis, leaving the school in character substantially what it is at present.

"If any medical school is to live in Indiana, two things are necessary, money and a modern organization. The essential thing in the organization is that it shall be controlled and directed constantly in the light of the highest ideals and methods in the medical world.

"To maintain such an organization is shown by the experience of the modern medical schools to be very expensive. It is true that eminent practitioners are willing to give their services for very small salaries. But there must be also some men who are eminent chiefly as scientists, who give most of their time to the school and who are paid accordingly. There must be a large staff of expert assistants some of whom must be paid. There must be elaborate and expensive clinical laboratories each with its chief and assistants. There should be a research hospital specially adapted for the investigation of diseases. These provisions are not ideal. They exist at the great schools and there the medical students will go and should go unless we are able to furnish them here.

"I strongly hope that a way may be found to organize an Indiana University medical school along the lines which I have indicated. I hope that the best of the Indianapolis medical men may cooperate in such an undertaking. I recommend that a committee be appointed to confer with the Indiana Medical School in regard to their proposal."

This report of President Bryan indicates his grasp of the status of medical education and his vision of the development which should be brought about, and indeed was brought about under the leadership of Indiana University.

The following letter in reply to the proposal of the Medical College of Indiana for union with Indiana University is of such importance as ex-

pressing the attitude of the University, it is here presented in full.

Bloomington, Indiana,
25th May, 1904.

Henry Jameson, M.D.,
Dean, Medical College of Indiana,
Indianapolis, Indiana.

Dear Sir:

On behalf of the Trustees of Indiana University I beg to acknowledge formally, as I have already done in an informal way, the communication from the Medical College of Indiana relative to the union of that institution with the Indiana University.

It is a pleasure to recognize our hearty agreement with you as to certain fundamental features of the present situation in medical education. We see that vast sums of money from various private and public sources are provided for almost every sort of education, including almost every sort of professional and technical education. We see that by far the largest contributor to all these educational enterprises is the whole people acting through the State and National governments. We see, however, with astonishment that one great department of education has been left for the most part to shift for itself and that precisely the one which concerns itself with the care of human life. We are clear in the conviction that this unaccountable discrimination against the profession of medicine is wrong, and that it is our duty to devote a generous share of the money placed in our hands by the State of Indiana for the support of high grade medical education. In carrying this purpose into effect we wish by all means to work with the men who have represented the best traditions of medical education in the State. We have therefore welcomed your communication and have given it careful consideration.

1. The essential condition of union is that the school of medicine shall become an integral part of the University.

We all understand the futility of a merely formal alliance.

It is equally clear that an institution created and controlled by the State cannot under any circumstances give away State money to an institution which is independent of the State. State maintenance and State control are inseparable.

The medical school runs no risk in committing itself to the State. The trustees are indeed not physicians. But as we all know, the American universities, generally including as they do every sort of professional and technical school, are controlled by laymen. The justification for this general American practice is its success. The Trustees of Indiana University are appointed in accordance with the laws of the State. They represent all parts of the State. In accordance with long established custom they come in equal numbers from the two chief political parties. Moreover, it is the proud tradition of the Board to exclude from its counsels partisan and personal considerations and to have an eye single to the highest interests of the University as a whole. There is therefore in the law and in the traditional spirit of the Board the highest guarantee that the medical department will be conducted upon the highest plane.

2. We are fully satisfied that it would be unwise to maintain permanently duplicate courses at two places.

Anyone of the laboratories necessary in a medical course is a very expensive institution if properly equipped and manned. We could not defend the maintenance of two sets of expensive laboratories, both doing the same work. Nor could we defend the permanent maintenance of one expensive and one cheap laboratory both giving the same courses.

Instead of such wasteful duplication of work we should unite all our forces and resources to establish one complete course of study in medicine which shall be in every

respect first-rate. As matters stand, I am of opinion that the first and greatest expenditure required would be in connection with the clinical courses. There should be as soon as possible a modern hospital entirely under the control of the medical department. There should be clinical laboratories equipped for purposes of instruction and research. There should be a staff of trained and paid assistants. The members of the medical faculty should receive salaries. We should spend for these objects many thousands of dollars within the next few years.

For my part, I wish to see the University concentrate its efforts toward this particular field, namely, the clinical courses in the school of medicine, until those courses are taken care of in a way befitting the State of Indiana.

If the views presented here meet with your approval, we shall be glad to confer with you further in regard to the details.

Very respectfully yours,
WILLIAM L. BRYAN.

This letter later was much quoted. The *Indianapolis News* in an editorial (May 4, 1906) refers to the expenditures urged by President Bryan for medical education as "extravagant," and so they no doubt seemed to many unacquainted with the high cost of high grade medical education. Yet those who knew realized its cheapness as measured by the advantages accruing to our people of Indiana in longer life, better health and lowered morbidity, following better control of scourges like typhoid, diphtheria, tuberculosis, etc.

In January 1904, a committee consisting of Messrs. Rose, Fesler and Hill, had been appointed to confer with Indianapolis physicians and surgeons on questions relating to a union of the Indianapolis medical schools with Indiana University. In June 1904 the question of union with one or both of the Indianapolis schools was further considered. The school year 1903-'04 ended with the strongest prospect of such union being made.

In the spring of 1904 an interesting and important opportunity presented itself as follows:

Two colored men working on construction of the Illinois Central Railroad near Bloomington had gotten into a bitter quarrel. One walked four miles to a neighboring camp to borrow a gun with which to shoot the other fellow. Unhappily for him, when he got back and went into action, his gun failed to work. But the other chap, meantime, had secured a gun which worked. So we had a perfectly fresh body which had been placed in our care a few hours after death and had been injected at once with a ten per cent formalin. This gave a marvelous embalming in case the body should be claimed by relatives, and it gave perfect preservation of the brain if the body should be assigned to us. When the twenty-four hours required by law for location of relatives had elapsed and the report had come to the State Anatomical Board that the dead man was a "bad actor" from down south, the body was definitely delivered to us officially by the State Anatomical Board. We at once removed the perfectly preserved brain and during the next nine months carried it through the dichromate fixation technique, imbedded it and cut it in serial

sections fifty mu thick which we stained by the Weigert Pal method, and mounted. This series of more than 2,000 sections was then divided into fifty sets, each set made up of every fiftieth section, and this series has been used for forty-five years (1949) by medical students, for the study of brain anatomy. This was the first complete series of brain sections in America available for class use. Previous to this, Doctor Sabin, of Hopkins, had made serial sections of a medulla, which she used in making her excellent model of the medulla.

In August of 1904 the medical committee of the Board was requested to investigate further the question of a union with the Medical College of Indiana, the Central College of Physicians and Surgeons, or both. A conference was held with the Medical College of Indiana on November 13, 1904, and the following day the president presented a written communication from Dean Jameson and stated "it appears the Medical College of Indiana wishes to become a part of Indiana University on terms satisfactory to the board."

In the Medical School Number of the Indiana University Bulletin, September, 1904, we find an outline of the two years of collegiate work required for admission to the Indiana University School of Medicine, important historically. The nineteenth century had closed with Johns Hopkins alone carrying the standard of higher entrance requirements among American medical colleges. In 1900 Harvard followed, then came Western Reserve in 1901 taking a stand for a more adequate premedical training. Then came the Indiana University School of Medicine, 1903, the fourth medical school in America, the first among state universities, to demand two years or more of collegiate work for entrance on the study of medicine.

On pages thirteen and fourteen of this medical bulletin of 1904 is outlined the work of the freshman and sophomore years of the School of Medicine. In this bulletin also are found reproductions of photographs of the laboratories of Anatomy, Embryology, Physiology, Neurology, Chemistry, and Bacteriology.

For a time Doctor Lyons, whose study in Germany had included Bacteriology, gave instruction in this subject.

In the fall of 1904 it appeared that an agreement might be reached for union of the medical educational interests of the state. This failed for the time, however, since the spokesmen for the Medical College of Indiana insisted on the maintenance of a four year medical course in Indianapolis, whereas, advisers of the University, men of national standing in the field of medical education, were urging the establishment of all four years at Bloomington in intimate relation to the other schools and departments of the University. This arrangement affords, as one of its desirable features, the impact of the serious and studious attitude of the medical student body on the general

student population, and the reciprocal impact of the student bodies of other schools of the university upon the medical student body, leading to an understanding and sympathy of various groups with the objectives of other groups.

The University during this period no doubt would have accepted a compromise on the basis of one or two years of the medical course in Bloomington and three or two years of the medical course in Indianapolis.

The only compromise possible, however, seemed to involve the giving of all four years at Indianapolis, thus duplicating the work of the first two years at Bloomington, and the University was not ready to commit herself to so expensive and wasteful a procedure.

The University, however, had definitely determined to develop the field of medical education assigned to her by legislative act in 1838, and was making substantial progress and winning recognition in this field.

In July 1905 the State Board of Medical Registration and Examination passed a resolution as follows:

"Whereas the Indiana State Board of Medical Registration and Examination having inspected the Medical Department of Indiana State University and found that the equipment and work done in the Freshman and Sophomore years in said medical department are of acceptable scope and character, it is the sense of the said board that the graduates of the said university who have taken the work of the medical department should, upon application for matriculation in any medical school, be given full credit for all work completed in the Freshman and Sophomore years of said university, credentials subject to inspection by this board as in other cases."

While, so far as union of medical schools was concerned, the year 1904-05 ended in a stalemate, the development of the University's School of Medicine was progressing in a most encouraging way, our students were given full credit in the leading medical schools of the United States, and they were voluntarily writing back letters expressing high commendation of the work they had had with us. The University authorities therefore continued to look with optimism to the time when all those interested in the progress of medical education in Indiana should constitute one big family, laying aside individual differences in the interest of a single great medical school under state support.

Summarizing the situation in the summer of 1905, at the close of the second year of the Indiana University School of Medicine, we note that outstanding progress had been made. All the work of the first two years of medicine would be offered in the year 1905-06. The school had been admitted to membership in the Association of American Medical Colleges and had been recognized by the Indiana State Board of Medical Registration and Examination. The school had received wide recognition and commendation for its position of leadership in its requirement of two years of collegiate

work for entrance. Obviously it was the purpose of Indiana University not to establish just another medical school. It was clear the University was pioneering in the solution of the difficult problem of advancement of medical education in the United States, not rushing the union with either of the old medical schools of the state, but was hoping for the development of a basis for union with both.

So the summer of '05 passed, and with the coming of September there was announced, in the *Indianapolis News*, September 1, a union of the Medical College of Indiana with Purdue University.

A situation was thus created that was wholly unforeseen by Indiana University. The legislative act approved February 15, 1838, conferring University status upon Indiana College, provided that the University should give instruction in certain named subjects "including Law and Medicine." Assumption of the obligation thus imposed was delayed because of lack of funds, though an experimental affiliation with the Indiana Medical College had been made, 1871-76.

Now that the University had begun the development of this important field of education, it was the purpose, as rapidly as possible to provide for those who were to care for the health and lives of people, a training equal to that offered anywhere in the world. To this end, and believing the field hers to develop as seemed wisest, the University had been proceeding deliberately (it now appeared too deliberately).

The question now was, what should be done? Should suit be brought to set aside the agreement between Purdue and the medical schools? Should the University establish a medical school in Indianapolis, or a four year medical course in Bloomington?⁶ Should the University retaliate by establishing a School of Engineering?⁷

At the meeting of the Board of Trustees, January 5, 1906, (p. 291) action was taken authorizing the extension of the work of the School of Medicine to a complete course of four years.

INDIANA UNIVERSITY SCHOOL OF MEDICINE

September 1905 to September 1907

An interesting and revealing sentence in the announcement of the union of the Medical College of Indiana with Purdue University was the following: "The Medical College is self-sustaining so it will not stand as a fixed charge on the University." This statement was repeated at a Senate hearing in 1907. This was, of course, exactly the type of union which President Bryan had been

⁶ The President discussed this possibility at length. He recognized that complete medical schools had been developed in small cities. All things considered, the plan seemed to him unwise; and he then, as at all other times, reported against it.

⁷ The President reported in detail on this possibility, which, as in 1903, was again rejected.

unwilling to make and had refused to make, as futile for the real advancement of medical education.

On September 28, 1905, the *Indianapolis News* carried the announcement that the faculty and student body of the Central College of Physicians and Surgeons had joined with the Medical College of Indiana in the union with Purdue.

The announcement of the inclusion of the Fort Wayne Medical College in this union was made on October 3, 1905.

These three schools united to form the Indiana Medical College (note change of name), the School of Medicine of Purdue University.

It had been learned that the building of the former Central College of Physicians and Surgeons, an almost new, well-appointed and equipped, substantial structure, could be purchased at a reasonable figure. There was necessary something slightly in excess of \$15,000 cash in addition to a mortgage which could be transferred. A meeting of Bloomington citizens was called at the home of Mr. James D. Showers. President Bryan stated the situation and these and other citizens of Bloomington, as in 1883 when the University buildings burned, rallied to the support of the University; the necessary fund was raised and title to this building of the Central College of Physicians and Surgeons was secured. This gave the University not only an excellent building in which to establish the work of the last two years of a medical course, but it was evidence that the University had powerful friends deeply interested in her welfare.

When the building of the Central College of Physicians and Surgeons was purchased, it was the expectation that the Indianapolis City Hospital would be available for bedside instruction. But when application for that privilege was made it was discovered that the Indiana Medical College had a contract for the exclusive use of the opportunities for clinical instruction in the City Hospital.

It seemed therefore, that the efforts of Indiana University and her friends to organize a school of medicine in Indianapolis for instruction in the work of the last two, the clinical, years of a four year medical course, were effectively blocked, unless we could organize our own hospital in the building of the Central College of Physicians and Surgeons. To do this presented one of the greatest difficulties, but in the end it proved one of the greatest advantages.

Doctor Myers was authorized to spend the summer of 1906 in Indianapolis transforming laboratories into hospital wards. The laboratory equipment, beautiful poplar laboratory tables and oak lockers and cabinets, had to be removed, walls painted, floors dressed, and beds and bedding installed. Operating rooms were to be equipped, a kitchen and nurses dormitory organized, and an elevator installed by which patients might be brought to first floor lecture rooms.

Space was reserved for a dispensary, and drugs were needed. A clinical laboratory was organized. There was no time for employment of an architect, so a two-by-four, twelve feet long, was laid on the floor and the outline of private rooms chalked on the floor. It must be understood all this had to be done in less than three months to make ready for an opening about the middle of September. And all this cost money. Happily, conferences of Indianapolis friends had already been held and the funds assured.

Much time during that summer of 1906 was devoted to organizing a teaching staff for the clinical years of the school of medicine, which was called the State College of Physicians and Surgeons, and in selecting a nursing staff for the State College Hospital. Furthermore, copy for the announcement of the State College of Physicians and Surgeons had to be prepared for the school year 1906-07, which was published in August, 1906.

At the meeting of the Board of Trustees of Indiana University July 19, 1906, the Board ordered the Executive Committee of Indiana University to make an educational affiliation with the State College of Physicians and Surgeons with the stipulation that Indiana University was to assume no financial responsibility for the affiliated school.

On September 18, 1906, the work of the full four years of the Indiana University School of Medicine and its affiliated State College of Physicians and Surgeons at Indianapolis, began most auspiciously with an enrollment of 109 students. The Hospital opened two days before the date planned in order to accept 13 typhoid patients from Fort Benjamin Harrison.

The work of the school year 1906-07 progressed, not without difficulties, but nevertheless very satisfactorily. The intimate association of our student body with the sick people of our dispensary and hospital offered an ideal opportunity for instruction. There were no problems of discipline. The opportunity for learning afforded our students was such that they "conducted themselves with a seriousness and dignity meriting the advantages of bedside study and worthy of a future practitioner of the best type," thus fulfilling the hope expressed in our announcement, that only those students desiring unusual clinical advantages should apply for matriculation with us. The great objective of the leaders of both schools (Indiana's and Purdue's) was the securing of authorization from the general assembly, meeting in January of 1907, for conducting a school of medicine in Marion County. Bills had been introduced by both Indiana and Purdue. The situation had become very tense. The officials and friends of each school were doing their utmost to sell their bill to the legislators. Statements were made by each school and given wide publicity.

There were dramatic legislative and legislative committee hearings. John Edwards of Mitchell

had introduced the Indiana University bill in the House, and Oscar Bland of Linton, then quite a young man, was sponsor for a companion bill in the Senate. Though the strength of the Indiana University faction was sufficient to force the Purdue bill from Committee, bring it to vote, defeat it, move its reconsideration and pass a motion to lay on the table the motion for reconsideration, its strength was not quite sufficient to pass the Indiana University measure. In the Senate, though the Bland bill had a majority, it was not a constitutional majority. So the bills of both schools failed of passage.

Judge Bland has recently written me reviewing the situation after adjournment as follows:

"After the fight was over, we (Indiana and Purdue) found we had the enmity of the non-state schools, and that they were combined against the state schools. It was realized by the Purdue men (Dan Simm and Will Wood) that if a fight like that continued, or if it were renewed, the legislature might withdraw its support from the state schools. Dan Simm and Will Wood came to me. They stated the enmity of the non-state schools to which I have referred and said: 'Now let us stop this fight. We will not ask to teach medicine and we will surrender the exclusive right to Indiana University to teach medicine.' We shook hands and were great friends afterward."

At the April meeting of the Board of Trustees the recommendation of the medical faculty of candidates for the degree Doctor of Medicine, was confirmed, and degrees ordered conferred on May 18, 1907.

At the August 1907 meeting of the Board of Trustees of Indiana University, Judge Vinson Carter, a member of the Board of Trustees of the State College of Physicians and Surgeons, recommended that the Indiana University School of Medicine and the State College of Physicians and Surgeons should unite under the name and style, the Indiana University School of Medicine. This recommendation was approved and a committee consisting of President Bryan, Mr. Fesler and Dr. Myers was appointed to meet with a committee of the State College of Physicians and Surgeons. This joint committee presented the following resolution, which was passed unanimously:

"Indiana University as one party, and the State College of Physicians and Surgeons, as the other party, hereby unite for the purpose of conducting a school of medicine under the name and style of Indiana University School of Medicine.

"Said Indiana University School of Medicine shall be the medical department of Indiana University. The organization effected by this union shall conduct a four years school in medicine. The first two years of instruction shall be given at Bloomington, Indiana, and the last two years at Indianapolis, Indiana.

"The course of study shall be prescribed and the faculty and officers thereof, chosen by the trustees of Indiana University. Indiana University shall confer the degree of Doctor of Medicine upon and issue the diplomas to the graduates of this school."

Thus without assuming any financial obligations outside of Monroe County, the position of the University was greatly strengthened.

THE SCHOOL YEAR 1907-1908

The school year 1907-1908 opened with a very encouraging increase in enrollment. In fact our freshman enrollment of forty-six was slightly greater than that of the combined schools of the Indiana Medical College, and this of course indicated a definite trend in our favor.

Lew Wallace in his very interesting book, *Ben Hur*, in describing the chariot race uses this sentence: ". . . and all the people drew a long breath, for the beginning of the end was at hand."

It was in this tense spirit the school year 1907-08 began. The two schools were located a block and a half apart on Senate Avenue. While there was no interfaculty fraternizing, the students of the two schools had certain contacts and there was little happening in either school that was not soon known in the other.

It would be quite misleading to give the impression we had no serious difficulties. We had optimistically organized a hospital of sixty beds. While educationally this was an element of great strength in our teaching program, economically it was our biggest headache. Only those who have had experience in hospital management will understand the multiplicity of imperative demands of such an institution, small though it was, and the variety and difficulty of the problems that arose, ranging from nurses' squabbles to butcher and laundry bills.

I well recall having gone up to the State College Hospital one morning in the late fall of 1907. As I entered the building I found a market man, red of face with high pitched voice demanding payment for some \$90 worth of meat furnished the hospital. He had scarcely left, somewhat placated, when a laundry man appeared demanding, equally vociferously, payment of an overdue \$70 laundry bill. When he had left, I will not say calmed, an investigation showed there was something in excess of \$2,000 in such bills. A conference was held with a few leaders. The result of this conference was that five people put in \$500 each and with this \$2,500 one man, Dr. Sowder, went about somewhat ostentatiously, paying these bills by cash, peeled from a big roll. It was soon widely reported that we had had a financial windfall, even that, through Indiana University, we had tapped the state treasury. Investigators were sent to the treasurer's office to discover this illegal use of state funds, and, of course, were unable to locate a treasury leak, since there never was one. But the opulence of the State College seemed unquestionable and her credit rating was high.

In reality, with these back bills paid, the State College succeeded in keeping out of the red to the extent of about one bottle of red ink, thanks to wonderful cooperation on the part of the clinical faculty in sending pay patients to the State College Hospital.

The president's report, November 5, 1907, to the Board of Trustees, with reference to the Medical School was optimistic. He said:

"I call attention to the report of Dr. Myers upon the status and outlook of the Medical School. I am glad to say that our situation is very much better than it has ever been. Our first two years is now fully established and is in every respect one of the best departments of the University. Our second two years is in a very promising condition financially and educationally. It is more and more penetrated with the modern University spirit.

"The whole school stands as justification for the judgment and policies of the Board of Trustees.

"The attitude of the medical profession has greatly improved even since last May. The fact that our class made one of the best records of any class in the United States before a State Board in May and the highest record ever made before our own State Board had a great influence in winning the respect of the medical profession. Our medical bulletin following this result helped again. Further still our faculty has been active in attendance at district and county medical meetings and, as you are aware, articles and addresses are being given before our faculty every Friday night and criticized with reference to their effectiveness before county societies."

We had our difficulties, and they were very great and very serious. But we also had our compensations. There was the compensation of the fine showing of our first graduating class made before the State Examining Board and referred to above.

Another compensation for the many difficulties encountered was the vote of confidence seen in our increasing enrollments.

Meantime an ominous situation was developing in the Indiana Medical College as revealed in the following table showing enrollments in that school from 1905-1908.

Year	Fresh.	Soph.	Jun.	Sen.	Total	Special
1905-06	54	67	94	124	339	
1906-07	45	59	49	73	226	
1907-08	41	44	45	52	182	2

This was a loss of 46% in total enrollment in the two years following the union of the three old medical schools, and entering classes were becoming smaller each year.

All things considered it was not surprising that in the fall of 1907 an overture came to us for a consolidation of the Indiana Medical College, with the Indiana University School of Medicine.

In the minutes of the Board of Trustees, for this November meeting we find that:

"A letter from Honorable John H. Edwards concerning a proposed union of medical schools was read and considered. On motion of Mr. Shea a committee consisting of President Bryan and Messrs. Shively and Rose was appointed to consider the proposition submitted through Mr. Edwards."

The letter of John Edwards of November 6, 1907, led to correspondence, propositions, counter propositions, and conferences, covering a period of five months.

The minutes of the session of the Board of Trustees of April 4, 1908 read as follows:

"The entire morning session was devoted to a discussion of the medical situation.

"The entire afternoon session was devoted to a discussion of the medical situation and final action was deferred to the evening session."

Finally the following resolution was adopted embodying the conditions of union acceptable to Indiana University:

"Resolved that the following tentative proposition be presented to the Trustees of Purdue University in adjustment and settlement of the Medical School controversy and if accepted the (Board of) Trustees of Indiana University hereby pledges its best efforts to secure the necessary power and authority to carry out its provisions fully and completely in all respects:

"After careful consideration the Board of Trustees of Indiana University does not concur in the proposal for a joint board of control for the Medical School. The following proposals are submitted:

"That the Medical College of Indiana (the Indiana Medical College, the School of Medicine of Purdue University) be united with the Indiana University School of Medicine under the direction of the Trustees of Indiana University. That the faculties of these two schools be invited each to nominate from its membership those who shall become members of the united faculty. That hereafter appointments be made to the medical faculty in the same manner as in all other departments of the Indiana University, the Trustees seeking the counsels and recommendations of the members and the officers of the faculty. That each department be supervised by a committee composed of the members of the faculty belonging to that department. That the two years of work in medicine shall be maintained in Bloomington as at present. That a complete four year course in medicine be undertaken and conducted in good faith in the city of Indianapolis."

This resolution was presented to the representatives of the Board of Trustees of Indiana Medical College, and of the Board of Trustees of Purdue University and was accepted by them, following which President Stone gave to President Bryan a communication pledging that:

"Whenever the contract^a embodying the agreed upon provisions shall have been executed between the Indiana University and the Trustees of the Indiana Medical College, the School of Medicine of Purdue University, the Purdue University will relinquish its interest in said school."

Then "a statement concerning the consolidation of the Indiana University School of Medicine and the Indiana Medical College was agreed upon by Presidents Bryan and Stone, was signed by them and ordered given to the public."

The statement of the presidents was as follows:

"The efforts of Indiana University and of Purdue University to promote medical education in the State, through cooperation with the members of the profession and with existing proprietary medical schools have been undertaken in good faith and with the one aim of establishing this important branch of professional training upon a sound educational basis.

"Indiana University has sought for many years to establish and develop such a department, in which efforts it has encountered many obstacles, but has made continuous progress. Purdue University entered the field only when convinced that a service could be rendered to the profession and to the State by the tender of its offices in consolidating existing forces and aiding in the evolution of a single, strong medical school at Indianapolis under the auspices of the State and with the cooperation of other educational interests, a task which was undertaken only after it seemed that other efforts in this direction had failed.

^aIt should be noted that the contract to which reference is here made, was between Indiana University and the Indiana Medical College.

"Out of these efforts by the two institutions had grown an unfortunate controversy, which operated to confuse the situation and becloud in the minds of the public the true relations of the universities. In the belief that the present conditions are delaying the educational progress and interfering with the highest functions of the two universities the logical conclusion follows that the two medical schools now in operation in Indianapolis under the direction of the two universities should be united into one school, and that this should be under the exclusive control of one or the other of these institutions.

"Since Purdue University has at no time regarded a department of medicine as an essential part of its program and on the other hand Indiana University believes that it has been especially charged with the responsibility for such instruction, the latter institution has been selected to proceed in the matter and the ruses of the two universities have this day mutually agreed to the following conditions, to which the faculties of their respective medical schools assent, namely: to a union of the two medical schools under the direction of Indiana University; to a selection of the faculty of the new school with due regard to the members of the present faculties, and to the maintenance of a complete medical course in Indianapolis as well as the two-year course in medicine at Bloomington.

"Only in this way does it seem feasible to accomplish the ultimate purpose of developing for the State a sound system of medical education, which has been the aim of both parties in their efforts in the field; as well as to promote those harmonious and friendly relations so essential to the proper discharge of the functions of both institutions.

"It is hoped, therefore, that the citizens of the State, whether remotely or intimately interested in this question, will accept the above decision as evidence of the disinterested motives of these institutions, and their desire to serve the State with undiminished energies.

Signed W. L. Bryan,
Pres. Indiana University,
W. E. Stone,
Pres. Purdue University."

On May 20, 1908, following the union of the Indiana Medical College with the Indiana University School of Medicine under the name of the latter, Dr. Henry Jameson, dean of the Indiana Medical College tendered his resignation to President Bryan, in order to leave the president free to make his own appointments. Though Dr. Jameson's resignation as dean was accepted he was appointed as professor of medicine in the new faculty.

On May 20, 1908, the graduates of united schools came to Bloomington for graduation exercises, conferring of degrees and presentation of diplomas.

A very delicate problem still remained; viz., the selection of the faculty of the united school. For this difficult task the president appointed the following committee: Drs. Edmund D. Clark, Alois B. Graham, Miles F. Porter, and Dr. Frank B. Wynn, from the Indiana Medical College faculty; Drs. John F. Barnhill, James H. Ford, Frank F. Hutchins, and Dr. Burton D. Myers, from the Indiana University School of Medicine faculty.

President Bryan acted as chairman of this committee which made a trip of nearly a week to visit Johns Hopkins University School of Medicine, the University of Pennsylvania School of Medicine, Columbia and Cornell in New York City, and Harvard in Boston.

In intervals between visits to medical schools and dinner conferences on medical education, there were meetings of the committee in which the selection of the faculty was worked out.

The report of this committee was accepted in good spirit by the respective faculties, formal appointments were made and both Indiana University and the Indiana University School of Medicine were launched upon a new era of development.

The following table shows the faculty members of professorial title as reported by this committee on faculty, arranged by departments. For the sake of completeness, the faculty of the first two medical years at Bloomington is shown, though not a part of this committee's report. It will be understood that in addition to the preclinical faculty at Bloomington there was also a preclinical faculty at Indianapolis, beginning with John W. Sluss and ending with Charles F. New.

PRECLINICAL FACULTY

	The Indiana Uni-Indiana Medical College, School of Medicine and affiliated State College of Physicians and Surgeons.	
Anatomy	Burton D. Myers A. G. Pohlman	John W. Sluss Walter S. Barrett Norman E. Jobes John E. Morris William B. Robinson Instructors
Embryology	Carl H. Eigenmann Charles Zeleny	
Physiology and Pharmacology	Wm. J. Moenkhaus Dennis E. Jackson	Lecturers and Associates
Chemistry and Toxicology	Robert E. Lyons Louis S. Davis Clarence E. May	William O. Gross (Ft. Wayne) Gustav A. Petersdorf C. S. Woods
Pathology and Bacteriology	Henry R. Alburger	Charles F. New

CLINICAL FACULTY

Therapeutics	Wm. H. Foreman* Thos. W. DeHaas*	C. Richard Schaeffer
Medicine	Allison Maxwell* Simon P. Scherer* Samuel E. Earp Chas. R. Sowder* Samuel C. Norris	Henry Jameson George W. McCaskey Frank B. Wynn John N. Hurty Louis Burckhardt* George D. Kahlo* Albert Kimberlin Theodore Potter Francis O. Dorsey Roscoe H. Ritter William T. S. Dodds L. Park Drayer (Ft. Wayne) James H. Taylor O. N. Torian* Ernest C. Reyer Albert E. Sterne* Charles F. New John H. Oliver Miles F. Porter (Ft. Wayne) Edmund D. Clark Jos. Rilus Eastman* David Ross
Pediatrics	John A. Lambert Amelia R. Keller	
Mental and Nervous Diseases	Frank F. Hutchins* Robert N. Todd	
Surgery	James H. Ford* George M. Wells Maynard A. Austin Horace R. Allen*	

Gynecology	R. O. McAlexander	Orange G. Pfaff
	Sidney J. Hatfield*	Thomas B. Eastman*
	David Kahn	Thomas B. Noble*
		Hugo O. Pantzer*
Gastro-Intestinal Surgery	John C. Sexton*	Bernays Kennedy
	Thomas C. Kennedy	John Q. Davis
	Walter Given*	George J. Cook
	Homer H. Wheeler*	Alois B. Graham
Genito-Urinary Surgery	John A. Sutcliffe	Wm. H. Wishard
	Harvey A. Moore*	Fred. R. Charlton
	John F. Barnhill*	Lewis C. Cline
	E. DeWolfe Wales	John T. Kyle
Rhinology and Laryngology		Kent K. Wheelock
		(Ft. Wayne)
		John L. Masters
		Lafayette Page*
Ophthalmology	Thomas C. Hood*	Albert E. Bulson
		(Ft. Wayne)
		Frank A. Morrison
		Frederick C. Heath*
Dermatology	E. O. Lindenmuth	Harry C. Parker
		Alembert W. Brayton
Obstetrics	Henry F. Beckman	Albert M. Cole
		Edward F. Hodges
		Chas. E. Ferguson*

The men of professional title of the clinical faculty of the Indiana University School of Medicine are listed in two columns, by departments. In the first column are the names of the men of the clinical faculty of the State College of Physicians and Surgeons, affiliated with the Indiana University School of Medicine under the name of the latter. In the second column are the names of the men of professorial title of the Indiana Medical College, made up of members of the faculties of three medical schools, namely, (1.) The Medical College of Indiana, (2.) The Central College of Physicians and Surgeons, and (3.) the Fort Wayne College of Medicine.

In each column the men who had been members of the faculty of the Central College of Physicians and Surgeons are starred(*). The men who had been members of the Fort Wayne College of Medicine are indicated by (Ft. Wayne) following their names. Men of the Indiana Medical College, not designated by an asterisk (*) or (Ft. Wayne) were members of the faculty of the Medical College of Indiana.⁹

It will be noted that more than half of the men of professorial title in the clinical years of our school, the State College of Physicians and Surgeons, 15 out of 29, had been members of the faculty of the Central College of Physicians and Surgeons.

Of the 55 men of professorial title in the Indiana Medical College (9 in the preclinical and 46 in the clinical years), 40 were from the Medical College of Indiana, 10 from the Central College of Physicians and Surgeons, and 5 from the Fort Wayne College of Medicine.

In all of these old school faculties there were men of superior ability as practitioners and as

teachers, men who would be a credit to any medical faculty today. One is tempted to call some of them by name, in which case there would be some of great merit possibly omitted. These names are here recorded and their former students who admired and loved them will revere them as they merit.

In the June 1908 number of the *Indiana Medical Journal*, Alembert W. Brayton published his article, "The Great Peace," which included the following paragraph:

"The primary contention of President Bryan that to the Indiana University belonged the traditional and natural right to harbor the learned professions—law, medicine and theology—is just and true, and it is to his everlasting credit and wisdom that he never lost sight of this principle when the question of the single state medical school finally came before the Legislature."

At the June 1908 meeting of the Board of Trustees:

"On motion of Mr. Shea (p. 418), the Executive Committee of the Indiana University School of Medicine was ordered to consist of the President of the University, the officers of the Medical School at Indianapolis, the Secretary of the Medical School at Bloomington, and Mr. Pesler."

"Drs. Allison Maxwell and B. D. Myers made statements regarding the medical situation."

The officers of the Indiana University School of Medicine which now represented a union of all nonsectarian medical schools of Indiana were announced by the president of Indiana University as follows:

William Lowe Bryan, Ph.D., L.L.D., President of the University.

Allison Maxwell, A.M., M.D., Dean of the School of Medicine.

Edward F. Hodges, A.M., M.D., Vice Dean.

Burton D. Myers, A.M., M.D., Secretary at Bloomington.

Edmund D. Clark, M.D., Secretary at Indianapolis.

John F. Barnhill, M.D., Treasurer.

The management of the affairs of the school at Indianapolis rested essentially with an executive committee which consisted of:

Doctors Wishard (chairman), Barnhill, Clark, Myers, and Wynn.

This Executive Committee referred its most difficult problems to a large Advisory Committee consisting of:

Dean Maxwell and Doctors Barnhill, Clark, Earp, T. B. Eastman, Ford, Hutchins, Jameson, Kimberlin, Lyons, Morrison, Myers, Oliver, Porter, Sowder, Sutcliffe, Wishard, Wynn.

This was not a mere paper organization, but a functioning organization. The advisory committee met frequently and in the best spirit worked out the problems of the school as they arose. The Executive Committee in the early years met every week or two.

One of the difficult problems with which the year 1908 and '09 began was that, though the University now had a complete medical school in Indianapolis in addition to the two pre-clinical

*To avoid confusion we repeat that this school was known as the Indiana Medical College from 1869 to 1878; as the Medical College of Indiana from 1878 to 1905. In 1905 it again became the Indiana Medical College (School of Medicine of Purdue University).

years in Bloomington, the Administration had no authority to expend any part of University funds in support of a medical school in Marion County. Authority to make expenditures for such school could not be secured before the meeting of the General Assembly in January 1909.

The Act authorizing the University to conduct a medical school in Marion County, Indiana, was passed by the General Assembly, February 26, 1909. Two provisions of this Act deserve special mention. The first was that there should be opportunity for the sectarian schools then recognized by the state to teach the practice of medicine according to principles advocated by those schools. This opportunity was provided on an elective basis explained to the schools prior to the passage of the bill.

This provision was included in fairness to the Homeopaths, the Eclectics, and the Physiomedes. Among these so-called irregulars were some very superior men, who were unfaltering in their support of higher standards of medical education and higher requirements for the practice of medicine. Three such men in 1908 were on the State Board of Medical Registration and Examination. One was Dr. W. T. Gott of Crawfordsville, a Homeopath, for many years secretary of the Board; another was W. A. Spurgeon of Muncie, a Physiomed; the third was M. S. Canfield of Frankfort, an Eclectic; all of these were men of high ability and vision.

The Homeopaths never established a school of medicine in Indiana, but at the time of the amalgamation both Eclectics and Physiomedes had schools, that of the Physiomedes being the oldest school under its charter name in Indiana.

Since no students elected these sectarian courses they were never given.

The second provision of the act of 1909 to which attention is called we quote as follows:

"Provided, further, That premedical or other collegiate work done in any college or university of Indiana, which is recognized by the state board of education of Indiana as a standard college or university, shall be received and credited in the Indiana University School of Medicine upon the same conditions as work of the same kind, grade and amount done in the department of liberal arts of Indiana University."

The terms of this provision, through the years, have been faithfully carried out, making such adjustments for peculiarities of grading systems or values attached to letter grades as place students of all schools of the state on an equal basis as candidates for admission.

It will be recalled that the Indiana University School of Medicine had been organized in 1903 with the requirement of two years of collegiate work for entrance. After being in force three years, 1903-06, this requirement, due to the contest that had developed, was given up temporarily. With the union of all schools with Indiana University School of Medicine in April, 1908 it was the purpose to return to the requirement of two years of collegiate work for entrance on the study of medicine at an early date. The date of reestablishment of this

entrance requirement was stepped up somewhat by an action of the Association of State Universities in accordance with which members of the Association must require two years of collegiate work for entrance to professional schools. It was recognized that the membership of Indiana University in the Association of State Universities should not be jeopardized by delay in introduction of a requirement already decided upon. Accordingly in the year 1909-10, one year of collegiate work, and in 1910-11, two years of collegiate work were required for entrance in the Indiana University School of Medicine.

This increase in entrance requirements of the School of Medicine gave rise to a decrease in the number of students entering medical school. For the United States this decrease reached its lowest point in 1919, when the total number of students in the medical schools of the United States was 13,052, less than half the total enrollment of medical schools in the early years of this century.

In the agreement signed by President Stone and President Bryan April 4, 1908, two items were of special importance: "the maintenance of a complete medical course in Indianapolis, as well as the two year course in medicine at Bloomington."

This agreement was signed in good faith by both institutions and with the approval of the Indiana Medical College in the conviction that the pattern of organization of the Indiana University School of Medicine was being determined for all time. The announcement in the Medical Bulletin read as follows:

"Students have the opportunity of taking the first two years of their medical course either at Bloomington or at Indianapolis. In both places the work meets the requirements of the Association of American Medical Colleges. Tuition is the same at both places. Final examinations are also the same. The choice rests with the student."

And, again:

"Students desiring to matriculate should submit credentials in advance to the Secretary either at Bloomington or at Indianapolis. By so doing an estimate may be made of qualifications for entrance, and uncertainty and unnecessary delay will be avoided."

The following table shows how that agreement worked out.

Year	Freshman		Sophomore	
	Bloom.	Indpls.	Bloom.	Indpls.
1908-09	34	35	35	42
1909-10	36	31	28	32
1910-11	20	6	23	35
1911-12	31	4	--	22
1912-13	42	--	--	34

It will be observed that for two years attendance at Bloomington and at Indianapolis was almost the same. Then in 1910-11 there was a sharp drop in freshmen matriculations, particularly marked at Indianapolis. In the fall of 1910 as stated above, the requirement of two years of collegiate work for admission to the School of Medicine, temporarily abandoned, was reestablished. A reduction in the number of entering students had been anticipated, but the great disparity in attendance at

Bloomington and Indianapolis was wholly unexpected. Dr. E. D. Clark, secretary at Indianapolis, was in charge of matriculation at Indianapolis. Doctor Myers was secretary at Bloomington. Students desiring to enter the Indiana University School of Medicine contacted officers of that school either at Bloomington or at Indianapolis. Neither secretary had any contact, prior to matriculations, with students consulting the other secretary. All were equally surprised when, on the opening of the school year 1910-11, it was learned there were only six freshmen enrolled at Indianapolis.

This uninfluenced choice on the part of entering freshmen students, indicated in the table above, presented a problem.

At a meeting of the Indianapolis faculty of the School of Medicine, in Indianapolis in June 1911, President Bryan presented the fact that there had been only six freshmen at Indianapolis during the past year, as a matter for consideration, and then withdrew in order that there might be the freest possible discussion and action. After full discussion action was taken calling for emphasis of the work of the freshman year at Bloomington, and of the sophomore year at Indianapolis. In conformity with this action, the sophomore year at Bloomington was abandoned and the full time sophomore faculty members transferred to Indianapolis. At Bloomington, Owen Hall, then vacant, was inexpensively remodeled for the departments of Anatomy and Physiology, providing for these two departments of the freshman medical year at Bloomington greatly improved quarters, which were occupied in the fall of 1911. But the work of the freshman medical year at Indianapolis continued to be offered.

It should be noted that the agreement made by Presidents Stone and Bryan with approval of the Indiana Medical College was now modified by a faculty, the great majority of which were members of the former Indiana Medical College faculty. It was like a reversal of a Supreme Court decision, or a repeal of an Act of Congress in the light of a changed situation.

Turning again to the above table, we note that during the school year 1911-12, there was an increase of 55% in freshman matriculation at Bloomington, and a decrease of 33½% in freshman matriculation at Indianapolis, with no sophomore medical students at Bloomington. Again conferences were held and in the bulletin of the School of Medicine issued May 15, 1912, an announcement was made, reading as follows:

"During the past year there have been but four freshmen at Indianapolis. The per capita cost of providing instruction for so small a number has been unjustifiably great, depleting the funds available for the courses of the last two years. Under these circumstances it will be necessary next year to charge freshmen at Indianapolis a fee approximately equal to the per capita cost. This amount will be announced later."

The amount of this fee was never determined. The cost, however, would not have been exorbitant

for a class of reasonable size since the work of the freshman year at Indianapolis was given by part-time men. Freshman instruction at Indianapolis in the year 1911-12 cost the school \$570 per student. A few inquiries regarding this fee were reported over a period of years, but no student matriculated and asked for the work of the freshman year at Indianapolis, which, however, continued to be announced in the bulletin of the School of Medicine, for many years.

Applications for matriculation at Bloomington grew to numbers far beyond our capacity. For a period of years the freshman medical class was selected from more than a thousand applicants.

Indiana University School of Medicine was one of five schools in the United States to which more than 1,000 students applied for admission. It was the only state university school of medicine in this group.

At the July meeting of the Board of Trustees, 1911, the recommendation of President Bryan that Charles P. Emerson, M.D., Johns Hopkins, 1899, be appointed dean of the Indiana University School of Medicine was approved. Doctor Emerson had studied in the Universities of Strassburg, Basil and Paris, 1901 to 1903. He had served as resident and associate in medicine at Johns Hopkins, and from 1908 to 1911 he had been superintendent of Clifton Springs Sanitarium (N.Y.). During the year 1909-1910 he had served as associate professor of medicine in Cornell University School of Medicine.

On October 8, 1930, the trustees of Indiana University spread of record an expression of sympathy with Dean Emerson who had become seriously ill. On July 23, 1931, on recommendation of President Bryan, Dean Emerson concurring, Dr. W. D. Gatch was made acting dean of the Indiana University School of Medicine. On June 1, 1932, Dr. Emerson was made research professor of medicine, and Acting Dean Gatch became dean.

THE NEW MEDICAL SCHOOL BUILDING

The building of the former Indiana Medical College was not old, but it had been erected just before the launching of the great advance in medical education which marked the beginning of this century. Since its construction the requirements of medical education had advanced remarkably. The building embodied the amphitheater type of medical school construction rather than the laboratory type of building, more and more recognized as essential. Indeed this building which housed the Indiana University School of Medicine in Indianapolis for ten years, had two large amphitheaters, one above the other.

In his report to the Board of Trustees, October, 1916, Dean Emerson spoke of the inadequacy of the old building. Since there were six medical schools within a few miles of the Indiana State line having physical facilities much better than

our own, the comparison of physical plants was made by many students, to our disadvantage.

The inadequacy of this old medical building had been still further augmented by a fire on December 7, 1916, which had caught from incubators in the pathology laboratory and had destroyed most of the third floor.

The Education Committee of the Medical School consisting of Doctors Emerson, Barnhill, Burckhardt, Clark, Gatch, Hurty, Hutchins, Lyons, Moenkhaus, Moon, Morrison, Myers, Oliver, Turner, Wishard and Wynn, meeting with President Bryan, discussed the need of a new building. The question of asking the Legislature for an appropriation was considered at length. It was reported by different members of the committee that the doctors of the state were taking the initiative in asking for an appropriation.

The committee went on record recommending that the need of the University for a new building for the School of Medicine should be presented to the State Medical Society. This idea was approved by the Board of Trustees, and Dr. E. D. Clark was selected as chairman of a legislative committee, with full power to select the other members of the committee.

The State Medical Society in business session:

"RESOLVED, That the members of the Indiana State Medical Association, express to the members of the State Legislature their firm conviction that the State of Indiana should provide adequately for the education of medical students, and heartily recommended to the State Legislature that a sufficient appropriation be made for a suitable medical building, as the present building was antiquated and thoroughly inadequate."

Dr. Oliver was elected president of the State Medical Society in 1916, so the continued active support of that body was assured.

At the December, 1916 meeting of the Board of Trustees it was ordered that a committee of three be appointed to present the views of the Board of Trustees to the Legislature.

After repeated conferences with the Governor it was decided to introduce a bill making provision for \$350,000 for erection and equipment of a building for the School of Medicine on grounds adjacent to the Robert W. Long Hospital.

The bill was prepared, introduced, reported favorably from the committee, and passed to second reading, where it was held up until near the close of the session (1917).

On February 3, 1917, diplomatic relations with Germany had been severed.

On February 10, 1917, there was a meeting of the Board of Trustees in Indianapolis. On the afternoon of that day the entire Board went to the State House for a conference with Governor Goodrich in which the urgency of the need of the new medical school building was emphasized. The influence of the Governor was sought in expediting the passage of this measure through an assembly which was known to be favorable.

Even the *Indianapolis News*, one of the most conservative papers in matters involving appropri-

ations and tax increase, joined the general urge for more adequate quarters for the Indiana University School of Medicine.

Three days before the close of the legislative session the bill passed the House by a vote of 86 to 5 and under suspension of rules it passed the Senate by a vote of 40 to 1. But the Governor exercised his right not to receive the bill on the excuse that the state of the treasury did not justify his signature.

On April 6, 1917 the United States declared war on Germany. As the year wore on and enlistment of medical personnel grew, the need for an increasing number of doctors of medicine and the desirability of speeding up of medical courses was emphasized by the war department. The need for an adequate medical plant was therefore no longer merely a matter of university and state interest, but had come to be a part of the problem of national defense.

The problem of financing construction of such a building was considered from every angle in every meeting of the Board of Trustees. With a favorably disposed General Assembly, the likelihood of passage of a bill providing for a new medical building had seemed so great that with a need so imperative the Trustees had authorized Mr. Daggett to prepare plans, which were now adopted by the Board of Trustees.

Since available funds were wholly inadequate this action merely gave the "go" sign when adequate funds should be available. There was an abiding faith that the necessity would open a way.

Governor Goodrich had finally realized it was not merely a need of Indiana University that was at stake. He had written President Bryan stating that the Finance Committee appointed by the last Legislature had decided they could appropriate \$130,000 to the State University for use in erecting a medical school building and he hoped to increase this total to \$150,000 from his contingent fund.

A few days later, the Governor again wrote President Bryan stating that he had overlooked certain items authorized for other institutions and that this would reduce the amount available for the Medical School building to \$125,000.

"After a general discussion of the proposition in the letters of Governor Goodrich, it was decided that the Board should agree to accept the proposal of the Governor to furnish funds to erect the building, providing the Governor accepts certain modifications of the conditions named in his letter."

One hundred twenty-five thousand dollars was a sum far from sufficient for the construction and equipment of an adequate medical school building. The best bid for this building as planned by Mr. Daggett was \$386,519. Bids were also taken on a part of the building, the best bid being \$238,574.75. In order that construction might proceed as a public necessity and as a war necessity, Governor Goodrich in June, 1918 proposed to the trustees of Indiana University that he ask a number of other public spirited citizens to join him in advancing credit of \$175,000, stating that he would ask the

Legislature at their next session (1919) to purchase the medical school building at the northwest corner of Senate and Market Streets.

The trustees accepted this proposal of the Governor who promptly called a conference of the following twenty-two men: George Ade, James A. Allison, F. C. Ball, Arthur V. Brown, H. F. Campbell, A. V. Conradt, Eugene H. Darrach, Thomas C. Day, Fred C. Dickson, W. T. Durbin, Edgar H. Evans, Fred C. Gardner, J. I. Holcombe, John H. Holliday, L. D. Huesman, William G. Irwin, Hugh McK. Landon, Josiah K. Lilly, James W. Lilly, W. C. Marmon, S. E. Rauh, and Theodore F. Rose.

The Governor presented his plan to these men who readily joined him in extending credit of \$175,000 to Indiana University for the purpose of erecting a new medical school building. The trustees of Indiana University let the contract on June 8, 1918 for the part of the medical building, costing \$238,574.75. Construction was begun without delay. In the fall of 1918 the president reported to the Board of Trustees that construction was well under way.

The twenty-two men who joined with the Governor in financing construction of the medical building had done so on condition that the Governor should lend his support to a bill, to be introduced in the next meeting of the General Assembly, January, 1919, which would provide a state appropriation for this building, thus releasing the guarantors.

In his message to the Legislature of 1919 Governor Goodrich recommended that the state purchase the old medical school building at the corner of Market Street and Senate Avenue, immediately west of the State House, for \$200,000, this sum to be applied to the fund for a new medical building.

While this recommendation of the Governor was under consideration by the Legislature, the Supreme Court of Indiana handed down a decision which made possible the repayment of the advance provided by the Governor and his associates in a manner quite different from that recommended by the Governor.

To make this Supreme Court decision understandable it must be stated in review that in 1913 the Legislature had made a special appropriation of \$65,000 per annum for the Indiana University School of Medicine and the Robert W. Long Hospital. In that same legislative session there was passed (March 1913) the 7c educational tax Act which repealed certain other appropriations. There was some question whether this \$65,000 per annum for medical school and hospital had been repealed.

Purdue University had a comparable situation involving some \$121,000 per annum which had not been paid for some years, and Purdue had instituted legal proceedings. The Trustees of Indiana University had not brought suit at the same time, for they had been assured by eminent legal counsel that the final decision in the Purdue case would apply with equal force to the appropriation of

\$65,000 payable annually to the medical school and hospital. It was the decision in the Purdue suit which had been handed down early in 1919 that these special appropriations had not been repealed. The back payments were therefore due from the State of Indiana. The back payments due Indiana University were compromised by the University for \$165,000 and the continuance of the appropriation of \$65,000 per annum.

Too much credit cannot be given Lt. Governor Bush for the legislative approval of this compromise. Governor Goodrich and Lt. Governor Bush had not always seen eye to eye on legislative matters. Though the appropriation bill, as passed by the Senate under leadership of Lt. Governor Bush, had contained the item of \$165,000 for Indiana University as compromised, the appropriation bill as passed by the House under control of Governor Goodrich, had not included this item. So a conference committee was appointed consisting of three Senators appointed by Lt. Governor Bush, and three Representatives. For a time both groups were unyielding while the clock, in this last day of the legislative session ticked on toward midnight. Finally the Senators of the committee convinced the Representatives that the Senate would not pass the appropriation bill unless it contained this item for Indiana University, in which case a special session would have to be convened. Whereupon the Representatives yielded and accepted the Senate's draft of the appropriation bill, and this report was accepted by the House.

By this action Indiana University was able to repay the advance credit underwritten by these public spirited citizens who had responded to the war emergency need for a new and more adequate medical building and they were relieved of any further responsibility in the matter.

The new medical building, located about 200 feet northeast of the Robert W. Long Hospital, was completed in the summer of 1919 at a cost of \$257,699.32, and was ready for use at the opening of the school year 1919-20.

In October, 1910, Dr. Robert W. Long, of Indianapolis, invited the president of the University to confer with him concerning the possible establishment of a state hospital in connection with the Indiana University School of Medicine. Doctor Long stated that for many years he and his wife had had the purpose of establishing a hospital in the city of Indianapolis, and had given much thought to the best ways and means of carrying their purpose into effect. Within the following three months Doctor and Mrs. Long went over the whole subject in all its details with thoroughgoing and businesslike care.

Doctor Long during his long practice of medicine had noted repeated instances in which the will of donors was broken, and he was very determined that every precaution should be taken to insure the disposal of his property in accordance with his wishes. To this end he had determined to make his bequest while living so that if attacked he

could join in its defense. The plan which gradually developed and found favor with Dr. Long was that of making his gift to the State of Indiana, for the use and benefit of Indiana University, whose Trustees should be authorized and empowered to accept the control and management of the bequest, and charged with the administration of the affairs of the hospital.

The conclusions which were reached were expressed in a formal proposal to establish upon certain stated conditions the Robert W. Long Hospital of Indiana University. This proposal together with deeds for property valued at two hundred thousand dollars, was placed in the hands of Governor Marshall on January 25, 1911. On January 26 Governor Marshall transmitted the proposal of Doctor and Mrs. Long to the General Assembly, accompanying it with a message recommending its acceptance.

The Senate and House of Representatives each placed these communications in the hands of suitable committees with instructions to prepare a bill which should provide the necessary legislative authorization. The bill as prepared embodied the proposal of Doctor Long. It was introduced by Senator Harlan, passed the Senate on February 2 by a vote of 46 to 0, and passed the House February 3 by a vote of 100 to 0, and was signed by the Governor on February 7.

In this manner Doctor Long enlisted all power and resources of the state in defense of his contract. Making this gift during his lifetime he had the pleasure of being consulted as to site and plans, and the gratification of seeing the hospital erected, dedicated and in operation.

After considering various sites and after consultation with members of the medical faculty, a site on West Michigan Street, in proximity to the Indianapolis City Hospital, at first rejected as a dump, was finally selected and purchased February 28, 1912. The wisdom of this selection is obvious today. The site of our present medical center is now very attractive and promises to become more so. Ground was broken for the Robert W. Long Hospital on the West Michigan Street site on November 1, 1912. It was dedicated June 15, 1914, and the first patient was admitted the following day.

The hospital is planned with reference to its use as a teaching hospital. The Legislature of 1913 confirmed the action of Governor Marshall in authorizing the securing of the present site and appropriated fifty thousand dollars (\$50,000) for its purchase. By two other appropriations the state assumed the permanent maintenance of the Robert W. Long Hospital. Later gifts of Doctor and Mrs. Long increased the total of their gifts to \$240,000. The hospital has a total of 106 beds, 18 in private rooms on the first floor, and 88 in four public wards on the second and third floors. The hospital admits approximately 2,000 patients per year.

THE JAMES WHITCOMB RILEY HOSPITAL FOR CHILDREN

Dedicated October 7, 1924

In 1916, shortly after the death of James Whitcomb Riley, a score of Mr. Riley's friends held several meetings for the purpose of developing a suitable memorial for him. The project was discontinued temporarily because of the war.

In 1920, these same men met again and formed the James Whitcomb Riley Memorial Association. A Committee on the Establishment of a Children's Hospital was created.

It was found that the Board of Trustees of Indiana University, the Indiana Children's Welfare Association, and the James Whitcomb Riley Memorial Association had each been interested in the establishment of a hospital for children. These three bodies united for securing a fund for creation of the James Whitcomb Riley Hospital for Children.

It further developed that Governor McCray was interested.

On January 27, 1921 after discussing the proposition a subcommittee of the Board was appointed to draft a bill to be presented to the Legislature then in session providing for such a hospital. This bill was passed and approved on March 11, 1921. The bill provided for establishment and maintenance of a hospital to be known as the James Whitcomb Riley Hospital for Children. It was to be located in proximity to the Robert W. Long Hospital as a department of the Indiana University, and under the direction and control of the Board of Trustees of Indiana University. The bill provided for the admission of indigent Indiana children under 16 years of age and for payment of cost of care and treatment by the county from which commitment was made. Costs were to be paid the hospital by the Treasurer of State who was to collect aforesaid costs from the county.

The James Whitcomb Riley Memorial Association resolved to undertake to raise a large sum of money to be added to the building appropriation provided by the state.

It was agreed that 5 representatives from the Board of Trustees of Indiana University and 5 representatives from the James Whitcomb Riley Memorial Association form a joint executive committee. Hugh McK. Landon was elected chairman of this committee and F. E. Schortemeier was appointed secretary.

The Association became an Incorporation and completed arrangements to raise a fund to be at least \$250,000. The plan contemplated a million dollar structure in the next ten years.

The Joint Committee employed Robert F. Daggett as architect, and the real estate immediately north of the Robert W. Long Hospital was secured as a site for the James Whitcomb Riley Hospital. The City of Indianapolis had agreed to establish a convalescent park immediately east of this hospital site.

On September 15, 1923 there was a favorable report on the campaign for funds. Subscriptions totaled \$911,518. On October 7, 1923, formal exercises of laying the cornerstone of the hospital were held. The following day the contract for the kitchen, laundry and service plant was let. On October 7, 1924 the James Whitcomb Riley Hospital for Children was dedicated, and the beneficent work of this great hospital was begun. As of April 25, 1945, the cost of this hospital has been \$2,300,000.

The hospital has ward space for 200 children in addition to 60 convalescents. It is thoroughly equipped for occupational therapy. It cares for some 3,000 patients annually.

This great hospital was the gift of more than 30,000 citizens of Indiana.

THE WILLIAM H. COLEMAN HOSPITAL FOR WOMEN

Dedicated October 20, 1927

On June 15, 1924 Provost Smith reported to the Board of Trustees a gift of real estate valued at approximately \$75,000 by Mr. and Mrs. W. H. Coleman, of Indianapolis, said real estate to be held in trust by the trustees of Indiana University for the endowment of the following chairs in the Indiana University School of Medicine:

Ophthalmology, under Dr. Frank A. Morrison.

Surgery, under Dr. John H. Oliver.

Gynecology, under Dr. Orange G. Pfaff.

The income of the gift was to be divided equally among the three men during their lifetime. At the death of these men (or any of them) the income or principal in the judgment of the trustees was to be applied for the benefit of the three chairs named above.

This gift was a definite innovation in the history of the Indiana University School of Medicine. Mr. and Mrs. Coleman had suffered a grievous loss in the death of their daughter Suemna Coleman Atkins, April 16, 1924, in whose name the gift was made. During her life she had been much interested in sick and suffering people, and had been a director of the Florence Crittenton Home.

But Mr. and Mrs. Coleman had been considering a still greater memorial to their loved daughter in the form of a hospital for women. Contact had been made with Provost Smith with reference to this purpose, and under date December 16, 1924, Mr. Coleman submitted his formal proposal addressed to the trustees of Indiana University, in which property valued at \$250,000 was to be given Indiana University for erection of the William H. Coleman Hospital for Women.

This gift was accepted by the trustees of Indiana University January 30, 1925 and appropriate acknowledgment was made by President Bryan. Governor Jackson, on consultation with the Budget Advisory Committee, reported that an appropriation not to exceed \$50,000 annually would be made for maintenance.

A site was chosen August 17, 1926 just west of the Robert W. Long Hospital. General plans

for the hospital were completed and the contract for construction let. The gift of William H. Coleman was accepted by the Indiana Legislature, Mr. Coleman's proposal to the trustees of Indiana University being embodied in the Act. The hospital was dedicated October 20, 1927, in the presence of 300 guests. The total cost of the hospital was \$300,000. Mr. Coleman generously supplied the additional \$50,000 necessary for completion of the hospital in accordance with plans approved by him.

Mr. and Mrs. William Coleman stated that Indiana University had been selected to administer the gift in memory of their daughter Suemna Coleman Atkins, because as part of the Indiana University School of Medicine and Hospitals, the Coleman Hospital would be a teaching hospital, helpful in training physicians and nurses who would carry the beneficent influence of the hospital throughout the state and nation.

THE BALL RESIDENCE FOR NURSES

Dedicated October 7, 1928

As the plans for the Riley Hospital for Children developed it became obvious that with the erection of the Riley all of the utilities, service units, and staffs of the School of Medicine and Hospitals would become inadequate. Consequently a service unit was part of the first portion of the Riley completed. Furthermore it was contemplated that provision should be made for a Training School for Nurses which, of course, called for an adequate Home for Nurses.

The task of the Riley Hospital Committee had been very difficult. Though subscriptions for construction of the Hospital had reached an encouraging total, most subscriptions had been made on a basis of five annual payments, so the total of paid in subscriptions was far less than the total subscribed. The Riley Committee was under great pressure from subscribers who wished to see construction under way. The plans of the Riley Committee were for an institution so large, calling for an expenditure so great, that many faint-hearted persons of little vision were saying, "They'll never build it." This pessimistic view was affecting new subscriptions and threatening payment of subscriptions already made.

It was exactly at this time, when subscriptions were dragging and the Joint Executive Committee had built far beyond available funds, and approximately a million dollars was needed to ease the situation, that George Ball asked quietly, "Do you suppose it would help you to get the rest of it if we (Ball Brothers) gave you half?" At the formal dedication, October 7, 1928, Mr. Hugh McK. Landon related the incident:

"I sometimes think that the Lord has a sense of the dramatic. I know He loves the man of courage in a worthy cause. For it was while Louis Huesmann was sitting at my desk discussing with me this very situation which I have outlined, and while we were searching our minds and hearts for the most effective basis for another appeal to the good people who had already been so generous to the Riley Memorial Association—it was

at this moment, I repeat, that George Ball walked up and gave the answer. He asked what the situation was. We put the figures down on paper for him. After studying them for a few minutes he said, 'It looks as if you are going to have to find another million.' We agreed with his analysis of the figures and told him that we had just been cudgeling our brains for the best basis for making the appeal. He sat quietly for a moment and then in a modest, almost deprecatory way, he asked, 'Do you suppose it would help you to get the rest of it if we gave you half?'

"As long as I live I shall be grateful that Louis Huesmann had the satisfaction of hearing and answering that question, for he, more than any other man in our organization, deserved that most timely justification of his faith and devotion."

This splendid Ball Residence for Nurses has all the advantages found in the best dormitories for girls on university campuses. The gift not only made possible the construction of this home for nurses but it stimulated gifts from others. The campaign for funds for the Riley Hospital for Children was given fresh momentum and carried to a successful termination.

KIWANIS UNIT OF THE JAMES WHITCOMB RILEY HOSPITAL FOR CHILDREN

Dedicated January 7, 1930

On September 28 and 29, 1922, the annual convention of the Indiana Kiwanis District was held at Anderson. At this meeting Mr. J. W. Fesler and Mr. L. C. Huesmann, representing the Joint Riley Hospital Committee, appeared before the Trustees of Indiana Kiwanis District suggesting that inasmuch as assistance to underprivileged children was a major objective of Kiwanis, it would be a splendid thing for the district to undertake the raising of \$150,000 for erection of an orthopedic wing at the Riley, to be known as the Kiwanis Wing.

The project was discussed and approved by the District Trustees who appointed a committee to prepare a resolution to be presented at the business session of the convention.

At that time there were about 4,000 Kiwanians in the 56 Kiwanis Clubs of the Indiana District, so this pledge of \$150,000 meant an average contribution of about \$40, spread over five years at \$8 per year.

This action had the effect of creating a focus of interest in the Riley project on the part of 50 to 150 leading citizens in each of 56 communities of the state. Thus the adoption of this project carried influence far beyond the membership of Kiwanis.

Doctor Myers was elected district governor for the following year, 1923, thus assuring interested leadership for this great project, since the Riley, by legislative act, had been placed under the control of Indiana University, with the advice of the Riley Committee.

By January 1, 1924, District Governor Myers had secured additional subscriptions to a total of \$103,961.50 as reported by the Riley Executive Office. There were additional subscriptions made but not yet reported. The additional subscriptions

secured by District Governor Kress amounted to something in excess of \$150,000 by 1928.

It was decided that this addition should be permanently known as the "Kiwanis Unit of the James Whitcomb Riley Hospital for Children." The cornerstone laying occurred August 1, 1929. The Kiwanis Wing of the Riley was dedicated January 7, 1930.

THE ROTARY CONVALESCENT UNIT OF THE JAMES WHITCOMB RILEY HOSPITAL FOR CHILDREN

Dedicated November 17, 1931

In the early days of the campaign for subscriptions for building the Riley Hospital for Children, the Rotary Clubs of Indiana undertook the raising of a fund of \$250,000 for a distinctive feature of this great hospital, namely, the Convalescent Home. This is the unit in which those children who are not bed cases, but who require occasional check, or brace adjustment, etc., live and go to school during the often long period of convalescence.

On July 29, 1930, Mr. Hugh McK. Landon, president of the Board of Control of the Riley Hospital, and Robert E. Heun, of Richmond, chairman of the Special Indiana Rotary District Committee on Rotary Convalescent Unit of the Riley Hospital, joined in the announcement that the Rotary building fund of \$250,000 for a convalescent unit of the Riley Hospital had been oversubscribed and the tentative plans for immediate construction of the Convalescent Home had been approved by the Special Rotary Committee and the Hospital Board. Mr. Landon said:

"This marks an achievement in Rotary, so I am told, which has no parallel in the history of the organization. It marks another great step forward in the Riley Hospital program and fills a gap which has given us great concern."

It was the expectation that the Rotary Convalescent Unit would be a building more than 150 feet in length and more than half as deep, located on a tract set aside by the Riley Board and the Trustees of Indiana University for convalescent uses.

On November 5, 1930, the Board of Trustees of Indiana University, in session in Indianapolis, met with the James Whitcomb Riley Memorial Association Committee, and with a committee of the Indiana State Rotary. Mr. Daggett presented the tentative plans for the Rotary Convalescent Unit, which met general approval. On February 17, 1931, it was ordered that the officers of the Board be authorized to enter into a contract with Mr. Daggett for the plans and specifications of the Rotary Convalescent Unit of the James Whitcomb Riley Hospital. The plans and specifications were completed, contracts let, and construction begun.

Construction progressed rapidly. On April 28, 1931, there were the formal exercises of a cornerstone laying.

The formal dedication was held on Sunday, November 17, 1931. In the governor's monthly letter to Rotarians announcing the dedication there is a brief description of the Rotary Unit which we quote as follows:

"The Indiana Rotary Convalescent Home was built by a free will offering from Hoosier Rotarians. It is a three-story structure with an exterior of brick and Indiana limestone, faces south from a terrace immediately west of the present hospital. It will accommodate sixty children ranging in age from infants to those sixteen years old. It will have two school rooms accommodating twenty children each, a kindergarten, a library, a dining room, an assembly room, a therapeutic pool in the basement and quarters for the staff on the third floor."

The interest of Rotary in subscriptions for and construction of this convalescent home, had results on the general campaign for funds for the Riley. There were at that time 57 Rotary Clubs in 57 cities of Indiana. There were, therefore, that many centers of special interest which helped impress upon whole communities the importance and great merit of the Riley Hospital project, and gave an impetus to the general campaign for subscriptions.

The hydrotherapeutic pool of the hospital designed to furnish up to date facilities for treatment of infantile paralysis, spastic paralysis, spinal curvature, and all other deformities requiring development of muscles, was built jointly by Indiana University, the James Whitcomb Riley Memorial Association, and the Governor's Unemployment Relief Commission of Indiana at a cost in excess of \$72,500.

The pool itself is eighteen by thirty-five feet and had a depth from 2½ feet to 4½ feet. It is lined with ceramic tile. It is housed in a building thirty-five by sixty feet with a dressing room twenty-eight by forty-eight feet joining it to the Riley proper.

There is a special equipment under thermostatic control for maintaining the water at a given temperature, and provision for purification of the water.

This therapeutic pool is the outgrowth of very definitely improved results obtained in treatment of both children and adults by exercises in water, as demonstrated at Warm Springs, Georgia, and similar institutions. It was dedicated October 7, 1935.

* * *

These three additions, the Kiwanis Wing for orthopedic cases, the Rotary Convalescent Home, and the hydrotherapeutic pool, represent a capital investment of approximately half a million dollars, and add in very important ways to the facilities of the James Whitcomb Riley Hospital for Children, benefitting the Medical Center at Indianapolis, and contributing to instruction of students of the Indiana University School of Medicine.

STILL FURTHER PHYSICAL GROWTH, AND CHANGE IN ADMINISTRATION

When, in 1906, the State College of Physicians and Surgeons was organized in affiliation with the

Indiana University School of Medicine, Dr. Allison Maxwell was made dean of the faculty of that school. Dean Maxwell was the grandson of Dr. David Maxwell appointed as trustee of Indiana University in 1820, and the son of Dr. James D. Maxwell, trustee of Indiana University, 1861-92. On the union of all old medical schools with the Indiana University School of Medicine in 1908, Dr. Maxwell was made dean of the Indiana University School of Medicine and served until 1911. Dr. Maxwell held a very responsible position with the State Life Insurance Company and had taken the deanship with the understanding that a successor would be appointed at an early date.

We have stated that at the July meeting of the Board of Trustees in 1911 Dr. Charles P. Emerson was appointed dean of the Indiana University School of Medicine, and served until July 31, 1931. During the twenty years of Dr. Emerson's deanship the physical developments of the medical campus recorded up to this time, with the exception of the hydrotherapeutic pool, had been made. Throughout that time Dr. Emerson was very active in the meetings of the Association of American Medical Colleges which he served as president, and for ten years was one of the most trusted and respected leaders of that association. Furthermore during this period the prestige of the school grew year by year and the applications for admission increased to numbers five to ten times the capacity of the school.

Late in 1930 Doctor Emerson became seriously ill and on July 31, 1931, on recommendation of President Bryan, Dean Emerson concurring, Dr. W. D. Gatch was made acting dean, and on June 1, 1932 he became dean of the Indiana University School of Medicine. During his administration the hydrotherapeutic pool was completed and the new Medical Building at Bloomington and the Clinical Building at Indianapolis were erected. In the last five years of his deanship Doctor Gatch carried the school through the very difficult war period with its speeded up program of instruction.

It should be restated here for emphasis that when in 1903 the Indiana University School of Medicine had been organized, two years of collegiate work were required for entrance. At that time only two other schools, Johns Hopkins and Western Reserve, required more than the completion of the work of a four year high school for admission. The Indiana University School of Medicine, it should be remembered, was the third school in the United States to establish entrance requirements beyond high school graduation. This requirement was abandoned temporarily in 1906 with the organization of the State College of Physicians and Surgeons, but in 1911 at the time of arrival of Dean Emerson, the requirement of two years of collegiate work for entrance on the study of medicine was restored.

Doctor Gatch resigned as dean June 30, 1946. From that date until June 13, 1947, the work of

the school was directed by a "Medical Committee," with Dr. John D. VanNuys as executive secretary; on June 13, 1947 he was appointed dean of the school.

MEDICAL BUILDING AT BLOOMINGTON Occupied June, 1937

As early as 1927 the need at Bloomington of a building for the School of Medicine, for relief from the crowded quarters of Owen Hall had been recognized by the faculty committee on the Promotion of University Interests, which placed an addition to Owen Hall high on the list in the ten year building program. It was soon realized that Owen Hall was so constructed that it did not lend itself well to an addition.

By 1935 the need for a new medical school building on the campus at Bloomington had become acute. When freshman medical classes numbered thirty to sixty, Owen Hall had accommodated them comfortably. But enrollments had grown beyond all expectation. Increased enrollments called for increase in staff, but there was no place in Owen Hall for additional staff members. Applications for matriculation in the School of Medicine for ten years had been many times the number that could be accepted. For some years the number of applications exceeded one thousand.

Consequently, attention turned to the erection of a new building, and tentative plans were worked out by members of the departments, based on the Harvard building plan of two major wings connected by a part of the building providing a large lecture room, a common library, etc., of use to both departments.

The applications for grants to aid in the erection of a building for the School of Medicine and for the School of Education were made by the administration at the same time, and needs of each continued to be emphasized by the administration. But it happened that P.W.A. approved the grant for the School of Medicine earlier than that for the School of Education.

On May 18, 1935 it was ordered that the Board apply to the federal government for money with which to construct a School of Medicine building at Bloomington.

On December 28, 1935 there was presented to the Board of Trustees an offer from the United States of America, through the Federal Emergency Administration of Public Works, to aid in construction of a building for the School of Medicine, not exceeding \$211,342.

After discussion, a resolution accepting this offer of the United States to the trustees of Indiana University was adopted in approved form and spread of record, and A. M. Strauss of Fort Wayne was engaged as architect for the new Medical School building. It was also ordered that the Medical School building be located at a point near Third Street and Forest Place as designated on the plat of the University grounds. Ground was

broken February 28, 1936.

The medical building was completed in the early summer of 1937 at a total cost of \$476,750. Final inspection was set for June 14, and the Departments of Anatomy and Physiology moved from their quarters in Owen Hall to the new building where summer courses in Anatomy and Physiology were given.

The dedication occurred on November 29, 1937. Governor Clifford M. Townsend presided. He presented Senator Sherman Minton, who made the address of the occasion. An address was also made by Fred C. Zapffe, secretary of the Association of American Medical Colleges. Governor Townsend replied and introduced Acting President Herman B. Wells, who spoke in appreciation of the state and federal officers who had a share in procuring funds and in the construction of the building.

In the five years, 1903-08, the absorbing interest of the medical faculty was the firm establishment of medical education in Indiana under leadership of Indiana University. But the ideal of a medical school in which research should be a serious part of the activity of the medical staff was never lost. In his letter published in the *Indianapolis News* of May 2, 1906, referred to earlier, President Bryan mentions medical research as part of our objective. Later in this same paper he says there should be "clinical facilities for instruction and research."

This thought appeared again and again, and, in the years following, it was never omitted from plans for the future. At no time was there the thought that we should develop as a research institute. But at no time was the hope lost that the day would come when our staff and physical facilities would be such as to provide time and encouragement for investigative work.

With the erection of the new medical building at Bloomington adequate facilities for investigative work were made available.

The next requirement was a staff sufficiently large to free some time for such work. Happily that was provided. Additions to our staff have always been made with greatest care. They came to us with work accomplished and promise for the future, and with high recommendations of leaders in their respective fields.

In closing this final paragraph in the "History of Medical Education in Indiana," we express the hope that the ideal for which we all have labored for so many years shall not be lost, but that every full time man brought to our staff shall continue to be selected with reference to his capability as a teacher, together with his accomplishment and promise in the field of research.

Note: This history of medical education in Indiana has been abridged from the author's unpublished manuscript in his own words by Edgar F. Kiser, M.D., Indianapolis, Clinical Professor of Medicine and Lecturer in the History of Medicine, Indiana University School of Medicine.

(To be continued in August issue)

One Hundred Years of Indiana Medicine 1849-1949

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DOROTHY RITTER RUSSO, *Editor-in-Chief*

Prepared under the direction

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Third and Final Installment

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ONE HUNDRED YEARS OF INDIANA MEDICINE

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(Concluded from July issue)

IX

INDIANA DOCTORS IN WARS

Part One

WARTIME MEDICAL HISTORY TO 1914

DOROTHY RITTER RUSSO

ARMY surgeons came in a sporadic flow to posts in the Northwest Territory during the years of tension and clash now known as the French-Indian Wars. With the subsequent close of the War of 1812, marking the consummation of the independence of the United States from Great Britain, there were individuals among these emergency doctors who accepted the challenge of our undeveloped country and stayed on as private practitioners. We can only guess concerning the contributions made by those who lived here only a short time and left no recorded trace; many gave honored service to their communities, as attested in our county histories.¹

The Mexican War played its part in consolidating the United States, and Indiana contributed five regiments of volunteer soldiers in 1846 and 1847, with nine medical officers in charge of their health. Each of the regiments had a surgeon and an assistant surgeon with the exception of the fourth, which had one contract physician in attendance.

Those who served in the Mexican War suffered mostly from measles and diarrhoea. The former caused many deaths; the latter yielded to treatment by physicians and adjustment of the soldiers to the climate, water and change of food. Typhoid fever brought many sick soldiers into camp hospitals along the Rio Grande, where overcrowding and bad ventilation took their toll. Conditions have been reported as far worse in the private dwelling places in the city of Matamoras wherein commissioned officers were required by army regulations to be cared for while sick.² Some of the typhoid victims died from perforation of the bowels or ileum.

It is apparent from letters written by many soldiers to their families in Indiana that the stimulus of the beauty of the country, so different from the middle west, and interest aroused by things seen for the first time, brought better health to some of those Hoosiers who served in the Mexican War. Such a by-product did not appear in the Civil War, characterized by depressive effects.

¹ A long-time effort has been made by the Indiana State Medical Association to gather, in each county, names of physicians and biographical sketches; to keep references to published accounts; to record data unpublished or not easily available.

² "Recollections of Medical Service during the War with Mexico," by Alfred Patton, M.D., in *Indiana Journal of Medicine*, August 1874.

Indiana was deeply involved in the Civil War and contributed more than two hundred thousand men before it ended (74.3 per cent of her population capable of bearing arms). The physicians of Indiana who served as surgeons numbered over five hundred. Each regiment, in its early organization, had one surgeon and one assistant surgeon. Indiana's Governor, Oliver P. Morton, early became aware of the need for more medical aid, and in April, 1862 called for and received permission to send two additional surgeons to each of the 24 Indiana regiments in the field. The services of these special surgeons were in part paid by the state until the national government recognized the importance of adequate medical aid and appointed one surgeon and two assistants for each regiment. Temporary appointments continued to be made to meet emergencies. Severe battles brought illness to surgeons as well as to fighting men, from fatigue and exposure. Many times trouble arose when all the surgeons of a regiment were either sick or absent on detached duty.

There is difficulty in following records of individual medical officers because of the shifting of position from one regiment to another by transfer or re-enlistment. It is difficult, too, to estimate the number of private practitioners who served in some way in times of special stress. As all homes were affected by war conditions in large or small measure, so were all medical men faced with new problems.

The first call to arms brought an assemblage of raw troops to Indianapolis. Before the end of April, 1861, the first month of war, six thousand men had been housed in the hastily prepared Camp Morton, many in stalls with one end open to the weather. The site, still known as Morton Place, had been made the state fairgrounds in 1859, and its buildings were turned into administration centers and barracks. Power Hall was fitted up at once as a hospital and sick calls each morning brought minor cases to it for treatment.

Stories are told of cases of hysteria among men who were confronted with a complete change of circumstances. A rumor of poisoned food and water swept through the new camp and a wave of illness followed it. Their physician calmly ate a "poisoned" orange and drank the dreaded water in the presence of his excited men, remained in good health and burst the bubble of fear.

Serious cases were sent to the City Hospital, a new building not previously occupied. In fact, it had to be completed in haste to meet the need. On April 29th, 1861, it became an army hospital.

Regiments in the field were, for the most part, ill-prepared for health protection. Formed of boys not trained to look after themselves, they were directed by men unused to living without aids to comfort. An Indiana soldier in an entry of December 14, 1862, at Memphis, wrote in his journal: "Our camp is in a most miserable condition. The Bell tents with which the men are furnished afford scarcely any protection against such rains as this. I don't suppose there is a dry blanket in the company this morning, not a single plank nor wisp of hay to be had, so there is no alternative but to lie on the soaking wet ground; cases of chill and fever are becoming more numerous and no wonder . . . The surgeon has succeeded in getting up the large hospital tent and constructed bunks in it of poles, our sick who have lain in the mud and water for the last thirty-six hours are being removed and placed therein, until an ambulance can be procured to take them to the general hospital in town."³

Another non-medical man, writing of camp sickness, thus itemized the varieties: "Intermittent, typhoid, and vile, low-grade 'fevers,' for which there is no name, but resembling the Southern 'dengue' or 'break-bone.'"⁴

The military hospitals of 1862 were little more than shelters where the sick could be segregated from the well. Many of the patients died in spite of the best efforts of the surgeons. Exposure and poor fare for weeks before arrival at the hospital left many a man too weak and too depressed to make the necessary effort at recovery. In the need for housing the sick and wounded, large private homes were often fitted up as hospitals and served well a small group. Often school houses, churches, court houses or other poorly adapted buildings were put to use. Occasionally an edifice otherwise satisfactory had the disadvantage of being located in a region described as "low and sickly."

Ambulances and hospital tents provided for the battle fields of the Civil War seem crude, in the light of modern equipment. In August of 1861 each company in a small command was allotted one two-wheeled ambulance; each battalion of five companies, one four-wheeled and five two-wheeled ambulances; each regiment, two four-wheeled and ten two-wheeled ambulances. Horse-litters, composed of a canvas bed similar to a stretcher, were furnished to posts where the grounds did not admit the use of wheeled carriages. For hospital attendants in the field each company was allotted one steward, one nurse and one cook. One nurse was

allotted for each additional company and, for commands of more than five companies, one additional cook. Medical officers on the march and in battle were attended by an orderly who carried a hospital knapsack made of light wood covered with canvas and fitted with four compartments or drawers, containing a few instruments, dressings and drugs. Later governmental requirements show more attention to detail, better organization and supervision, and more equipment provided where more men were to be cared for.

The manuals issued for army surgeons are interesting evidence of the practice of the time. In treating wounds trephining was recommended for badly fractured bones in the skull; for face wounds, sutures and cold water dressing was recommended. Ligatures were of well-waxed silk. Anesthetics were still in an experimental era and were recommended only in event of a "thorough reaction." The day of depleting measures after operations had passed; stimulants, tonics and nutritious food were called for instead. Pneumonia, pleurisy and hepatitis slew thousands, and a constant battle was waged against typhus and typhoid fevers, dysentery, diarrhoea and scurvy. Common colds were not disregarded but were treated with hot drink, mild aperient, morphia (a quarter of a grain was suggested), opium (a grain), or Dover's powder (a large dose). It was recognized that proper sanitation was necessary to prevent the occurrence and spread of disease.

Statistics show that of the 196,363 Indiana volunteer enlistments from 1861 to 1865, 2,971 died of wounds and 17,785 of disease.

The Civil War's first wave of mass destruction was brought close to us by the battle of Fort Donelson. It was arranged that the wounded be cared for at Evansville, New Albany and Indianapolis. Governor Morton arrived at Fort Donelson on February 20, 1862, with a boat load of twenty-five doctors and nurses and with hospital and sanitary stores donated by citizens of Indiana. Upon his return he reorganized hospital service in Indianapolis, opened new hospitals in towns along the Ohio River, and sent surgeons and supplies to hospitals outside the state where Indiana soldiers were being treated. He urged the slow-moving national government to act more quickly to distribute money, food, clothing and supplies to spots in the field where men were suffering privations.

The Indiana Sanitary Commission which was formed on March 3, 1862 was a forerunner of the Red Cross. It served as a collecting and distributing agency for supplies of all kinds. Through this agency steamships were chartered to carry stores, surgeons and nurses to the wounded to relieve them on the field and to bring them home or to convenient hospitals. Charitable women of the state were encouraged to form patriotic societies. Sanitary fairs were fashionable, also productive of funds.

³ Eugene Thrall, "Journal of the Civil War," in the *New Harmony Times*, March 22, 1907-March 27, 1908.

⁴ *The Miscellaneous Writings of George C. Harding*, Indianapolis, Carlon & Hollenbeck, 1882, p. 214.

Well-organized, the Sanitary Commission functioned through agents in many cities, with headquarters in Indianapolis; one of the branches was in Evansville. The agents kept the public informed of current needs, kept records and helped Indiana's soldiers in many capacities. Part of their purpose was to reduce hospital service by preventive measures to keep well men well.

When the battle of Richmond, Kentucky, August 1862, brought a new disaster, Indiana sent a wagon train of thirty ambulances, six sisters of charity and two other women nurses, six men including experienced surgeons and a large supply of hospital stores and provisions. All went safely through the enemy's lines under a flag of truce.

In Evansville a Marine hospital had been erected before the Civil War, together with some small buildings to house convalescents. Early in the conflict the government added more buildings here, to which steamboats brought wounded Union men and Confederate prisoners. Refugees were cared for in a camp established in Blackford's Grove.

New Albany received two hundred sick and wounded soldiers in March, 1862. For the emergency temporary hospitals were fitted up, in three city school buildings. These were used for more than a year.

In December, 1862 Governor Morton asked for the establishment of a government hospital at Madison. In the spring of 1863 it was erected on the site of the old state fairgrounds and named Camp Dennison. In the winter of 1863 it housed as many as 1,200 soldiers.

Another government hospital was located in Jeffersonville during the Civil War but there seems to be little known regarding it.

The establishment of a prison camp in Indianapolis, at Camp Morton in February, 1862, brought 3,700 Confederates to it. Quarters were not ready for them and overcrowding was an added danger to men sick and exhausted. The emergency hospital at Camp Morton had only twenty-five bunks and the military hospital was already filled with wounded Union soldiers. Some of the prisoners had to be treated in the barracks at camp, some emergency cases were somehow made room for in the city hospital, and two more military hospitals were hastily set up in buildings on Meridian Street, one previously a gymnasium, the other a post office.

It has been claimed that men are better able to endure the hardships of military life in the field than the discomforts of a prison camp where despondency makes them an easy prey to disease. Much has been argued about cruelty in the prison camps of the Civil War. Among the prisoners at Camp Morton the death rate was 46.7 per thousand. The death rate in the Confederate Army was generally high, due probably to extreme privations in the way of clothing, food and hospital supplies.

All the ills of warfare were aggravated as time went on and men suffered in field and camp and hospitals from hunger, exhaustion and exposure. They were all prime subjects for pneumonia, bronchitis and typho-malarial fever. Scurvy was as great a menace as small pox and measles. Hookworm prevailed through lack of shoes, and intestinal troubles through lack of good food. A weary nation was relieved when this war between brothers was called to a stop. Wounds to the mind and spirit and body needed healing.

The next combat which brought America into a war had a much less direct effect than the Civil War on Indiana's persons and institutions. The pronouncement of war with Spain, received here on the evening of April 25, 1898, found the military department prepared and the National Guard was promptly mobilized.

Indiana supplied five regiments in the Spanish-American War, the 157th to 161st, and thirty-four medical officers. These were detailed as 5 regimental surgeons, 11 regimental assistant surgeons, 3 surgeons in the volunteer army appointed by the President, and 15 hospital stewards. None of Indiana's regiments were engaged in actual warfare.

An Illinois surgeon, Dr. Nicholas Senn, has written in considerable detail the military story of this war⁵; as far as is known there is no similar chronicle by an Indiana medical man. The place of the Spanish-American War in medical history seems to be that of a testing ground of methods and equipment in emergency and on foreign ground. It showed the need of national organization, executive leadership and trained medical personnel. It also opened the curtain to scenes of wide implication when a World War ensued less than twenty years later.

⁵ Senn, N.: *War Correspondence* (1899) and *Medico-Surgical Aspects of the Spanish-American War* (1900).

IX

Part Two

THE INDIANA PHYSICIAN IN WORLD WAR I

WILLIAM DEPREZ INLOW*

In the first place, war has changed. Surgery has changed. Everything has changed.

COL. BAILEY K. ASHFORD, M.C.

WAR was far from the thoughts of the Indiana physician during the decade and a half following Spanish-American hostilities. There were those still living who spoke of Civil War days, but this greatest of all fratricidal struggles now seemed remote and unreal. The masterly series of essays on military surgery appearing in the newly founded *Surgery, Gynecology and Obstetrics*, by that prince of midwest surgeons, Nicholas Senn, interested chiefly the scholarly minded. There were concerns closer—the fight between Purdue and Indiana Universities for control of the merged medical schools of the state, the public health turmoil kept up by pertinacious John N. Hurty, the stake of starting the profession's own periodical. Frank W. Foxworthy of Indianapolis, fresh from the Philippines, alone in all this time talked of warfare.

* * *

June 23, 1914, Archduke Francis Ferdinand, heir apparent to the Hapsburg thrones, and his morganatic wife were assassinated at Serajevo, Bosnia.

The first notice of the impending cataclysm was taken by the Indiana State Medical Association in August:

"The war preparations in Europe have tied up trans-Atlantic transportation and made it almost impossible to obtain money in Europe on letters of credit or exchange. Hundreds of doctors who have been attending the Clinical Congress of Surgeons in London and visiting clinics on the continent will be greatly inconvenienced as a result of the difficulty in securing return passage and money for expenses."

Inconvenienced? What about the Belgians?

Austria-Hungary sent Serbia an ultimatum; July 28 she declared war. July 29 Russia ordered partial mobilization. July 31 Germany demanded of Russia that she cease preparations within twelve hours, required of France answer by the morrow as to her attitude. August 1 Germany declared war against Russia; France mobilized. August 2 the Germans pronounced the right to cross Belgium. August 3 Belgium prepared to defend her neutrality, appealed to Great Britain; Germany declared war on France. August 4 Britain gave Germany an ultimatum not to violate Belgium, but the uhlans were already on the move; that night Britain declared war on Germany.

Breathtaking was the rapid course of events. The Teutonic hordes, held up briefly before Liège, moved southwestward like an avalanche into France. Exultantly they pursued the retreating Allies. Repeatedly the French and British were on the verge of disaster. September 4 Von Kluck reached a point only seventeen miles from Paris. September 6 the French and British, turning on the invaders, began the first battle of the Marne. For four days the outcome hung in balance, then swung in favor of the Allies. The German bid for speedy victory had failed. The conflict in the west settled down to trench warfare.

"Doctors Eastman, Wood and Clevenger have returned from the war zone in Europe apparently with much the same feeling as the man who has escaped from a burning house."

The exodus was general. There returned likewise J. C. Kelly of Mitchell, M. M. Clapper of Hartford City, Frank Holland of Bloomington, Howard Shafer of Rochester, C. O. Bechtol of Marion, Marcus Ravdin of Evansville, G. M. Lsalle of Wabash, J. E. Doerr of Mt. Vernon, H. H. Martin of LaPorte, F. H. Jett of Terre Haute, Joseph Rubsam of Logansport, E. F. Hodges of Indianapolis. Charles A. Pfafflin who had been studying in Berlin did not arrive till October 26. Frank Crockett of Lafayette, Linn Rogers of Logansport and Melvin Mix of Muncie sent word that they would stay till traveling conditions proved more favorable. Crockett was temporarily appointed assistant House Surgeon in St. Peter's Hospital, London, to take the place of the regular incumbent who had gone to war. But even this early the trek back had started. C. C. Rayl of Monroe, who had only lately got back from a year's stay abroad, received an appointment to return as surgeon with the American Red Cross; Brown S. McClintic of Peru was one of thirty-three such who sailed September 6 for duty in the war zone.

The first flurry over, medical life in Indiana went on pretty much as it always had. The 65th Annual Session of the State Association met in Lafayette, September 23, 24, and 25. Though a grim reminder of the meaning of war was present not far away in the battleground of Tippecanoe, there were no discussions dealing with war or the role of medicine in war. How complacent and self-centered the profession! How wrapped up in paltry personal affairs!

"The editor of the 'Journal,' Albert E. Bulson, Jr., is anxious to secure for publication some practical articles dealing with the business side of the

* Shelbyville. Senior Surgeon Inlow Clinic.

practice of medicine. Every physician should be a business man as well as a doctor and he can assume this role without resort to objectionable commercialism. . . ."

"The European war has played havoc with the prices of many drugs and chemicals, especially those that are manufactured abroad. . . the lesson taught is that we should so modify our patent laws as to make it incumbent on foreign manufacturers to provide for the manufacture of the products in this country in such emergencies as at present. . . ."

"American watering places should profit by the European war. . . . There is absolutely no reason why Americans should visit Wiesbaden, Carlsbad or any other European watering place through the mistaken notion that those places are superior to anything we have in this country . . . This reminds us that there never was a better time for boosting our American health resorts and we therefore call attention to the well known sanitariums advertised in 'The Journal.'"

"'Wanted: 5,000 Christian Scientists, osteopaths, chiropractors, vitapaths, neuropaths, spinologists, mental healers and representatives of any other class of incompetents who are pretending to care for the sick and suffering to go to Europe and serve in the Army Hospitals or as physicians on the field of battle!' Such an advertisement might, with all propriety, be sent out by the American Red Cross Association or by the Medical and Surgical Departments of the various European countries . . . were it not known that these pseudodoctors are of no use whatever when it comes down to the real test of caring for stricken humanity. When the people are ravaged by pestilential diseases or the terrible destructiveness of war, they call out in their need for 'real' doctors. . . . They want none of the pretenders. . . ."

Withal it was not suggested that any *bona-fide* Doctor of Medicine join the Red Cross or the hospital staffs of any of the combatants. Rather the Indiana physician was to look forward to the close of the war when, due to the new knowledge developing in consequence of the varied and enormous experience that had come to the leading surgeons of Europe, the Clinics would be a fruitful field of study for him who wished then to make the rounds in London, Paris, Berlin and Vienna!

Such at first was the degree of insouciance of Indiana medicine toward the world's unexampled travail.

* * *

In 1915 there was an awakening.

It was the plight of the Belgians that most aroused the conscience of America. Vast quantities of food and clothing were shipped. The profession was asked to contribute to the relief of those medical men who had lost not only all their worldly possessions but the opportunity of reestablishing themselves in practice.

Control of the seas had been seized by the Entente from the first. February 4 the Germans, relying on mines and submarines, announced that all waters about the British Isles would be treated as within the zone of war, that neutral shipping would be in grave danger. March 11 the British established a virtual blockade.

A fortnight later the *Lusitania* was sunk. A wave of horror and anger swept over the United States. One hundred twenty four of the dead were Americans. For the first time the possibility of entrance into the war was brought home to Indians. A period of diplomatic exchange followed, with continuing anxiety until late fall.

In 1916, on the last day of May, the main fleets of Great Britain and Germany met in the great battle of Jutland. A week later the *Hampshire*, carrying British Secretary of War Kitchener, struck a mine off one of the Orkney Islands and sank. It was none too propitious a time to be sailing in British waters. Nevertheless June 17 Joseph Rilus Eastman of Indianapolis put to sea with six surgeons and six nurses to spend some time in charge of the Austrian units sent out by the American Physicians' Expeditionary Society.

The large electrically lighted sign "Ryndam" was on the bows of the ship while a huge searchlight kept the flag of Holland astern conspicuously visible. All life boats swung out on the davits. The vessel put up at Falmouth, most southwesterly of English ports, during two days, for disembarking passengers and taking the ship's manifest to London. At night the harbor and town were pitch dark, the tower and mast lights of the vessel out, the port holes covered, as measures against zeppelin attack. The wireless apparatus was dismantled; visit and search made by British officials. On departure the craft, to avoid the channel, made its way through the Irish Sea and around the northern end of Scotland, threading through the treacherous rocks of the Orkneys in dense banks of mist. The lookout over the cut-water could see only a few yards ahead. Early one morning there was a frightful shock followed by ominous scraping; the ship had gone on the rocks. It took a full hour for the great liner to free itself. Lying at anchor till the fog disappeared it made for Kirkwall, waiting for passage while the submarine nets were hauled in.

The party went by small boat directly east to the Norwegian coast, then south to Rotterdam, thence overland to Vienna. In a letter home Eastman reported:

"Our institution is a modern military hospital situated at the southern margin of the city. It rests on an elevation overlooking the beautiful Wienerwald and in view of the high mountains at the junction of the Carpathians and the Alps. . . . Patients are brought . . . from the transport trains in automobile ambulances . . . The secretaries secure at once a succinct personal and clinical history . . . while the barbers are clipping off the hair and the whiskers. The cooks come from the kitchen bringing hot soup and rolls. Cognac, wine, beer and coffee are dispensed . . . The . . . amiable chaplain moves about . . . with words of comfort . . . and with cigarettes for all. He graciously . . . lights those for the soldiers himself. All clothing is removed from the wounded and taken to the disinfecting room. Each man is then blanketed and carried to the bath where he is smeared with blue ointment and placed in an individual tub."

That spring it had not been the Germans who had exacted the greatest attention from Hoosiers, but the Mexicans. March 9, Francisco Villa and his brigands had crossed the border. Six days later General John J. Pershing had entered Mexico in pursuit. In June the Indiana National Guard was mobilized at Fort Benjamin Harrison for dispatch to Texas. Among the doctors called out were Majors Larue Carter and Frank Foxworthy, chief surgeons; Majors Frank B. Humphreys, Angola, and Earl S. Green, Muncie; Captains John W. Emhardt, Indianapolis, and George F. Holland, Bloomington; Lieutenants Arett C. Arnett and Don C. McClelland, Lafayette; and Keene, Clark and Pfaff of the Medical Reserve of the Regular Army.

The chief problem was the prevention of the gastro-intestinal disorders which had played such havoc in the Civil and Spanish-American wars. Two doses of typhoid vaccine containing a strain of Paratyphoid B supplied by Will Shimer of the State Bacteriological Laboratory had already been given. Each train leaving Fort Harrison had a surgeon, several members of the hospital corps and an ample supply of drugs, including Squibb's diarrhoea mixture. Provisions were good, but culinary equipment lacking and the preparation of food bad. For the long journey the men were crowded into old day coaches. Protest was made to the Surgeon General, but the only result was reprimand from the Central Department of Chicago. In spite of this the Colonel of the "First Indiana" commandeered some Pullmans and baggage cars in the St. Louis yards. On arrival the force was stationed at Llano Grande, a wilderness of mesquite some sixty miles up the river from Brownsville. The giving of the third dose of the vaccine was interdicted (it being maintained that the reaction was too severe), and government material substituted. However, though paratyphoid was epidemic a short distance away, none occurred in the Indiana troops.

The camp got its water by canal from the Rio Grande River. In it Major F. C. Robinson of Martinsville discovered an enormous number of small white worms, probably mosquito larvae, as well as sand and vegetable debris making straining and boiling necessary. Later the Lister water bag, a large circular canvas contraption vulcanized on the inside and made to hang by several ropes to the limb of a tree or to the ridge pole of a tent, was employed. The contents of a small tube of hypochlorite of lime was put in which after several hours rendered the water free from infectious material.

Incinerators of mud had to be used at first, though eventually one of brick with iron chimney was built. The latrines were deep pits covered by wooden boxes brought all the way from Fort Harrison, rendered as fly proof as possible, burned out daily by the use of straw, hay and crude oil. Flies were a pest, for though fine mess houses

had been built it was several weeks before sufficient wire was furnished to screen them.

Many men of the Third Infantry had to sleep for weeks in small shelter tents affording neither protection from the sun nor from the excessive rainfall.

There was no provision for care of the sick at the regimental infirmary. A camp hospital was started by Captain A. G. Chittick of Frankfort in a two-story rambling old house with about twenty small rooms and two verandas, known as the "Casa Blanca."

This Mexican episode exposed in glaring fashion the inadequacies of the American military establishment, the defects in organization and equipment of the Medical Department. The Advisory Committee of Civilian Physicians and Surgeons on Medical Preparedness presented a recommendation to President Wilson advocating appointment of committees in each state to make comprehensive surveys of their medical resources.

* * *

With the beginning of 1917 the Germans, after having given false hope by putting out insincere peace feelers, resumed unrestricted submarine warfare. Barred zones were established into which neutral vessels were forbidden to enter. The situation rapidly became critical, leading the United States to sever diplomatic relations. Toward the last of March it became known that three American ships had been torpedoed and American lives lost. April 6 America declared war.

Soberly, and perhaps a little guiltily, the *Journal*, which during the preceding two and a half years had done nothing to ready the physicians of the state for this contingency, bemoaned:

"The unfortunate phase of the situation is that we are totally unprepared. No matter how boastful we may be concerning our resources—and we must admit that we are the most boastful people on earth—yet the plain unvarnished truth is that we are unprepared according to present day standards of war; . . . our country has gone blindly on lulling itself into security with the thought that if the worst comes we shall be able to marshal our forces and our resources on the spur of the moment to combat nations that for many years have been on a war footing. How absurd and illogical!"

The Germans knew that more than a year must pass before America could become a real factor. The regular army on April 1 numbered less than 128,000. There were on duty in the Medical Department 491 regular medical officers, 342 temporary officers, 86 officers of the Dental Corps, 62 veterinary officers, and 6,619 enlisted men. Ten medical officers and 100 enlisted men per 1,000 troops was considered a necessary ratio in war time. The Medical Department did not have the personnel to form even a skeleton for the body of medical men needed.

The first doctor called to active duty was Victor T. Keene, Indianapolis, on April 13. Because of the congested condition of the Surgeon General's office medical boards in various parts of the coun-

try were established to handle applications for the Medical Officers' Reserve Corps. At the start Keene was given this function for Indiana.

England early had not conserved her medical forces so that now she was urging the United States to send 3,000 doctors. One hearkening to this call was Charles R. Bird of Greensburg, who sailed May 15 in a group of about 50 physicians and nurses with the Harvard Surgical Unit for Britain.

As the state began to mobilize, those serving with the Central Powers arrived home. Paul F. Martin, who had left in May the year before for duty in hospitals in Bohemia and Vienna, arrived in the United States May 21; Will C. Moore, who had worked in Germany and Austria (reporting earlier that he would stay another six months) showed up May 31. Eastman, detained in Copenhagen, got back April 24 after a hazardous trip across on a Standard Oil tanker. He did much to dispel the illusion that the people of Germany and Austria were starving and would soon quit:

"Every inch of ground is under cultivation; for example, along the roadsides up to, and between, the wagon ruts. The people have grown accustomed to the business of war. They have staked everything on victory. They have invested so universally in the war loans that they feel that they are indeed fighting for existence; and if they cannot win, they may as well, as we say in Indiana, 'let the tail go with the hide.' They are not likely to give up unless torn asunder by revolution."

When the Indianapolis Chapter of the Red Cross, February 9, received the offer of Josiah K. Lilly to give \$25,000 for outfitting a base hospital of 500 beds as a memorial to Colonel Eli Lilly, it was accepted the same day. After war came organization of the unit sped apace.

There was much to be bought. The original sum proved less than half enough necessitating augmentation by funds transferred from general subscriptions to the Red Cross and an additional \$15,000 from Mr. Lilly and his wife. John H. Oliver was appointed chief. Changes in the staff originally chosen soon became necessary. Oliver, David Ross and Frank Morrison were disqualified on account of physical disability; Charles H. New, born in Canada, because he had failed to take out naturalization papers. June 14 Edmund D. Clark succeeded to command. The Lilly unit became United States Army Base Hospital 32.

The center of military activities in Indiana was Fort Harrison. May 12 the first officers' training camp was established. Representative young men from Indiana, Ohio, Kentucky and West Virginia were chosen to be the first candidates for commissions. The buildings were only partially completed, the equipment meager. Nevertheless the camp opened June 1 with 110 student officers. The course of instruction consisted of 10 hours work per day for 13 weeks. Other similar training periods followed. Three such camps had been

projected for the summer before, but had had to be abandoned on account of the Mexican trouble. Again the Indiana National Guard was called into service. June 11 Major Larue D. Carter's Field Hospital 1 from Indianapolis and John Nicodemus's Ambulance Company 1 from Frankfort went into encampment at Fort Harrison. July 14 it was announced that the Guard was to be trained at Camp Shelby, Hattiesburg, Mississippi. The place was not an inviting one, being in the heart of the cut-over pine district with chiefly stumps, sand and goats. Field Hospital 1 left August 26; the last Indiana contingent arrived there October 13.

Major Clark announced the personnel of "32" on August 24: Majors Orange Garrett Pfaff and Bernays Kennedy; Captains Carleton Buel McCulloch, Alois Bachman Graham, Charles Dolph Humes, Eugene Bishop Mumford, Lafayette Page, Harry F. Byrnes and Joseph Kent Worthington; Lieutenants Scott Robert Edwards, Ralph Landis Lochry, Raymond Cole Beeler, Robert Martin Moore, Elmer Funkhouser, Leslie H. Maxwell, Paul Thomas Hurt, Smith Quimby, Ralph Lincoln Sweet, John Thomas Day, Joseph Warren Ricketts, Frank Columbia Walker, Jack Walter Scherer, James Vincent Sparks. The last two were dentists; Byrnes not an Indianian. There were also 180 men, 65 nurses and 10 civilians. Clark and Humes were sent to Philadelphia for special training in military surgery, Beeler to New York for x-ray study, Edwards to the Rockefeller Institute for schooling in the Carrel-Dakin treatment. Pfaff was left in command, but suffering a badly injured knee, had to be discharged.

The order came to send all equipment to Pier 41, New York City. Everyone was on the *qui vive*. All portents seemed to indicate early embarkation. The morning of September 1, the members of the unit left Indianapolis by special train amid the plaudits of the crowd, the officers in brand new uniforms. From the send-off one would have thought they were headed for the front, but it turned out that they were entrained only for the thirteen mile trip to Fort Harrison. Here they lived in tents till the weather got too cold, engaging in drill and studying the Articles of War. Life, with evening and Sunday passes back to the metropolis, hikes and rabbit hunts, visiting from the home folks, camp fires and singing, was not too severe.

The meeting of the Association of Military Surgeons was held at Fort Harrison October 8-10. Prominent doctors from civil life attended as well as army surgeons and representatives from the Royal Army Medical Corps of England and the French Medical Army Corps. At the assembling of the Indiana State Medical Association itself at Evansville September 26-28, John H. Oliver, first president to serve with the assistance of an executive secretary and a regularly organized headquarters, spoke officially of war for the first time since the conflict began:

"This is the third war since the birth of this society in which its members have been called to serve . . . and the burden is much heavier, and the sacrifice greater . . . Already 9.4 per cent of its members have gone gloriously forth and the call is still for more. The State Board of Defense, through its subcommittee on medicine, has about completed a statewide survey, covering everything pertaining to the war from a medical standpoint. . . . My hope, my prayer and my earnest belief is that the doctors of our country and particularly those of our beloved Hoosier state, will rise nobly to the occasion. . . ."

Under the Selective Service Act of May 18, 1917, the first call was for registration of all men 21 to 30 years old. The quota for Indiana was 17,510. There were to be no bounties, no provision for the purchase of substitutes as in the Civil War. An efficient organization had been perfected by June 5, the date of the first registration. Within the state were 4 district, 124 local and 102 medical advisory boards. The number of registrants was 255,145, each man being given a number. July 20 was National Draft Day; those whose numbers were drawn were required to appear before the boards for physical examination. Most of the recruits were sent to Camp Zachary Taylor, Kentucky. For assistance in the draft Governor Goodrich appointed physicians throughout the state to serve as third members of the County Boards of Conscription.

The fine showing ultimately made by Indiana medicine in enlistments for the Medical Reserve Corps was not attained till near the end. A large number of doctors in the beginning offered their services "in case of emergency" and "for the specialty" only. Performance was not up to pretension. More than 25 per cent of those who had applied for appointments and had received notifications to appear before the examining boards failed to show up. A few withdrew their applications. It was noticeable that it was the older men generally who applied and made good. Interns who were graduates of well recognized medical schools or medical students in their fourth, third or second year who had not been called by a local board could enlist in the Enlisted Reserve Corps.

It was difficult for most of the Indiana physicians who entered the service to realize that they had much to learn before they became competent officers, efficient sanitarians, trained military surgeons. Granted commissions in recognition of their professional attainments it was hard for them to recognize that nevertheless as soldiers they were novices. The first task of the Medical Department, therefore, was to provide for its Reserve Officers the necessary training.

June 1, 1917, Medical Officers' Training Camps were opened at Camp Greenleaf, Fort Oglethorpe, Georgia; Fort Riley, Kansas; and Fort Harrison, Indiana. The needs of the Medical Department required 3,000 medical officers, 500 officers of the Dental, Veterinary and Sanitary Corps, and 35,000 enlisted men to be constantly under training. These numbers, however, were never attained. Although

in the early stage most Indiana doctors were sent to Fort Harrison, as time passed an increasing number went to other camps, especially Greenleaf.

Instruction started June 15, 1917. Training consisted of a basic course of three months (cut down to six weeks in the summer of 1918) about which were clustered a number of special subjects. The student officers straggled in gradually. Those reporting after the beginning were required to attend night quizzes; those coming in the latter half of the course took what they could grasp and were enrolled in the next class. Half were trained for service on the zone of operations and half for duty in the line of communications. The first group consisted of younger men physically sound and mentally alert. The second group was made up of older men certified as fit for home or special duty only; they took an abridged basic course with additional specialized instruction.

During the total period June 1, 1917, to November 30, 1918, 6,640 officers and 31,138 enlisted men were received at Camp Greenleaf and 4,318 officers and 22,161 enlisted men departed. Sixty-three base hospitals, 37 evacuation hospitals, 5 field hospitals, 13 hospital trains, 5 ambulance companies, 21 evacuation ambulance companies, 9 convalescent camps and 10 replacement units were organized and equipped, the most of them being sent out.

Mobilization camps comprised the tent group for the National Guard and the cantonment group for the National Army. The organization of the various divisions was on or about August 25, 1917. The prescribed strength of each was approximately 28,000 officers and men, but various nondivisional organizations and casualties brought the population of the camps considerably higher.

Practically all the medical personnel in a camp during the early period was on duty with divisional organizations. Service was of two kinds, that with the sanitary train (a strictly medical outfit) and that with the combat units. The sanitary train was composed of four ambulance and four field hospital companies, one of each mule drawn, the others motorized, plus a headquarters staff. There were 49 officers (medical and a few veterinarian) with the sanitary troops, 55 with other divisional organizations.

Some of the doctors ordered to the divisional camps had had basic training, but many had not, being taken directly from civil life. These latter scarcely knew even how to salute. A few were so poorly advised that they arrived in camp in civilian attire. Many of those who were properly uniformed had been extravagant in their purchases coming with all sorts of foolish impedimenta, so that the *Journal of the American Medical Association* was constrained to comment scathingly: "True, umbrellas no longer appear—but they still bring swords and rocking chairs, and no doubt if the military equipment establishments sold walking spurs and guard lines some enthusiastic doctor

would be induced to buy. . . ." Advice as to proper outfitting followed.

One heavy weight serge uniform with cap for dress; one service blouse with the letters "U.S.R." and a caduceus on each side on the collar, with bars indicating the rank on the shoulders; two pairs of trousers with belt of webbing; two flannel shirts; one pair leather puttees; one pair Munson shoes, a half size longer and one size wider than ordinarily worn; a heavy regulation overcoat; two suits of underwear; two pairs of socks light weight, two heavy; gloves; a campaign hat with officer's cord, to be worn on all occasions except dress; a locker trunk; a cot; a bedding roll; Turkish towels; a Red Cross kit and toilet roll. Clothing to be woolen, in color olive drab. There were other suggestions. There should be a white linen collar with accompanying white cuffs for dress. Extra shirts and shoes could be obtained from the Quartermaster, as well as the overcoat; but in the last instance alterations would be necessary (and Quartermasters didn't alter). A trench coat—a sheeplined moleskin thing with a fur collar—would be useful but not necessary. Red Cross sleeveless sweaters were a great comfort but had to be worn inside the shirt; wristlets allowed and advisable. Woolen pajamas were a necessity, nightgowns ridiculous. Blankets should be taken along, thick warm woolen ones, preferably three, sheets in winter being about as useful as bedspreads. There should be two comforters, one woolen to wrap up in, one cotton of strong material to sleep on; and a small thick pillow, pillow slip unnecessary. A safety razor was best for often one had to shave without mirror and with cold water.

"In this connection it would be well to add that it would serve a good turn to practice daily bathing as it will be necessary in barracks. Also it is apropos to remark that it would be well to bring your table and home manners with you as you are expected to be housebroken while living with other men. A small, light typewriter is a great convenience. It will be possible to procure everything else needed on arriving except some ready money to carry you over until you cash your first pay check. We might add that pay vouchers are sent in on the 20th of the month and pay is received near the first by check of large denomination which is not always easy to cash."

This list though given as a minimum is nevertheless formidable. It was quite a hardship for many a young man recently out of school, who perhaps was already in debt for his training, to outfit himself. Many complained bitterly and justly about the cost. Dealers, knowing that officers had to furnish their own equipment, took advantage of the opportunity to charge exorbitant prices.

The training of those physicians going directly to camp had to be carried out in the cantonments themselves, but it was at first interfered with by the necessity of examining the members of the frequently arriving increments of the draft. The system finally developed was to combine all medical personnel into one unit with general and special

examiners. The usual plan was to have a definite number of inductees report at intervals. They were admitted in groups with orderlies and railings so placed as to guide them from one station to another. Undressing stations were generally placed at the start. The total examining personnel was about 34 officers assisted by 60 enlisted men. Usually there were three orthopedic, three neuropsychiatric, four cardiovascular and ten tuberculosis specialists. The number of men that could be run through daily depended mainly upon the available officers qualified to act as special examiners. The capacity of the average board was 400 men. Frequently, however, from 800 to 1,000 were passed through daily.

Many a newly inducted Hoosier physician must have felt like the rookie he really was. Ralph M. Funkhouser of Evansville happily expressed it:

"When you see a poor ungodly lookin' awkward
knock-kneed cuss
With his puttees put on crooked en his uniform a
muss,
Tryin' to stand up like a soldier, looking like he'd
like to be
Please don't let him hear you kid him—have a little
charity—
He's a Doctor."

* * *

For the members of Base Hospital 32 still stationed at Fort Harrison time dragged and impatience grew. When orders did finally come November 28, they were rescinded within the day. It was whispered that it would now be spring before departure for foreign service; but on Saturday morning, December 1, after many had left camp on pass, word was received to entrain for Hoboken at six. Apathy gave place to mad activity. Travel rations had to be secured, barracks cleaned, baggage packed. At Hoboken they were joined by the nurses. Sixty-five of these had left Indianapolis for New York City, September 9, for special training. Besides Chief Nurse Florence Martin, former Superintendent of the City Hospital, there were 11 nurses from St. Vincent's Hospital, 12 from the City, 14 from the Methodist, 4 from the Deaconess, 2 from the Robert W. Long and 1 from the Fletcher Sanitarium, the remainder having been recruited from private practice. Along with almost 8,000 others they boarded the *George Washington*, former German luxury liner. In company with it was a smaller transport, the *Huron*, the two being conveyed by the *Montana* and a torpedo destroyer. They sailed the night of December 4.

Three days out there was a severe storm, terrifying to landlubbers, but only a foretaste to the tempest met in the Bay of Biscay (after they were joined by six destroyers) which swept away the life boats on the port side of the *Washington*, smashed several of the lookout stations, and washed four men overboard. As the great transport neared Brest the destroyers laid down a smoke screen. Precautions against submarines were doubled, the guns manned. Suddenly to starboard a dark object bobbed into view. The ship's siren

screamed, a gun boomed. It was only a school of porpoises. Finally land began to show. Italian biplanes circled about the ship, little boats with maroon-colored sails drifted by. As the vessel came to anchor a mile or so out boats of every description crowded about while above floated two large captive balloons.

Disembarkation did not occur for two or three days. The special train scuttled across country on Christmas Day during a snowstorm, passing French troop trains jampacked with soldiers, stopping every now and anon at strange towns where the Hoosiers, hanging out the windows, hallooed their arrival. About three o'clock next morning they came to a stop at an unimposing little station where dozed a handful of loiterers. The first few off plodded through the deep snow up to the sign where they were able to spell out, "C-O-N-T-R-E-X-E-V-I-L-L-E". No one knew where this was. No one at the moment cared.

Contrexeville was in the foothills of the Vosges Mountains 230 miles east and a little south of Paris, about 50 miles behind the lines. It was a popular watering resort with a number of large hotels. In the central park was the *Établissement des Eaux* popularly known as the Colonnade. Many of the buildings were well adapted for military hospitals, having been used as such by the French until sublet to the Americans. There were the Cosmopolitain Palace, Hotel Royal, Hotel de la Providence, Hotel de la Providence Annex, Hotel de Paris, Hotel Continental, La Souveraine, Hotel de l'Établissement, Hotel Harmand, Hotel Martin Felix, Hotel Fluery, Hotel Martin Aine and the Casino. The first five grouped in the upper part of town were assigned to "32", the others being turned over to "31" from Youngstown, Ohio. The Hotel Moderne Annex was leased for headquarters, the Hotel de Paris Annex for officer quarters. The capacity of "32" was raised to 1,200, the additional beds furnished being of low French type. The original equipment was put in the six-story Cosmopolitain which was made the main surgical unit, Hospital A. The other buildings were designated Hospitals B, C, D, E. The first job was to make the structures fit for occupancy. Surgeries, laboratories and x-ray rooms had to be set up, requiring special lighting and wiring, the installing of sinks, the building of partitions, the supplying of benches and tables.

There were frequent changes in personnel. As first organized Major H. R. Berry was commanding officer, Major E. D. Clark director, Major C. B. McCulloch adjutant, Capt. Charles D. Humes registrar, Lieut. F. P. Bushey quartermaster. Clark was chief of surgical service with McCulloch in charge of Hospital A and Capt. Alois B. Graham of B; Major Bernays Kennedy was chief of medical service. Lieut. Joseph W. Ricketts was in charge of Hospital C, Lieut. Robert M. Moore of D, Lieut. Leslie H. Maxwell of E. On the staff with McCulloch were Capt. Lafayette Page, otolaryngolo-

gist, Capt. H. F. Byrnes, ophthalmologist, Capt. Eugene B. Mumford, orthopedist, Lieut. R. C. Beeler, roentgenologist. The increase in beds necessitated additional personnel so that a southeastern Iowa organization Unit R, was added. In March Major Van Kirk, a disciplinarian of the old school, assumed command whereupon the entire outfit was kept on edge with inspections and drill the order of the day. There were many shifts. Humes was sent to Base Hospital 8, Beeler to Chaumont, the first surgical team—Clark, McCulloch, Lochry—to Compiègne. Mumford joined Base Hospital 66. The second surgical team—Martin, Walker, Johnston—was transferred to the French Tenth Army, finally to Evacuation Hospitals 6 and 7. April 20 Clark returned. April 26 Quimby, Hurt, Funkhouser, Ricketts and Crow were ordered to the front with the 42nd or Rainbow Division.

The record of this division was one of the most distinguished of any in the war. Organized in August, 1917, it was composed of National Guard units from 26 states, later enlistments and replacements making it representative of almost all. With it was the 150th Field Artillery, the former First Indiana Regiment, under command of Col. Robert Tyndall, which had trained at Fort Harrison, having left for Camp Mills, L. I., on September 7. This unit had embarked for St. Nazeaire on October 18, being part of the first 60,000 American troops to set foot on European soil.

In the spring of 1918 France was in greater peril than at any time since the first battle of the Marne. The Germans began their great offensive March 21. At this time there were less than 370,000 American troops in Europe, about half of whom were noncombatants, but in the months that followed reinforcements came in a steady stream. In April 120,072 men embarked from the United States for France; in May 247,714; in June 280,434; in July 311,359; in August 286,375; in September 259,670; in October 184,063; in November 12,124. In all 2,034,000 American soldiers reached France, 1,390,000 seeing more or less active service at the front. Twenty-nine divisions took part in active combat service—7 Regular Army, 11 National Guard, 11 National Army. Scattered through these, chiefly the latter two, were the men from Indiana. Beginning July 18 the Allies assumed the offensive. Scarcely a day passed that they did not win some victory. In the last days of September they began their epic assault on the Hindenburg line. In all this fighting the Medical Department played its role.

* * *

In the front line were the regimental officers. The care of casualties took place chiefly at company aid posts and battalion aid stations.

The battalion aid stations were the real medical centers for the advance troops. They were

generally located at port trenches 240 to 500 yards from the front. When the distance was more than 1,000 yards relays of litter bearers had to be used. As constructed by our allies and taken over by our troops they consisted of a series of communicating underground rooms designed to withstand heavy bombardment. One room was for office and reception of patients, one for application of dressings and shock treatment, one for the battalion surgeon, one for stores and one for the personnel. They had galleries with two or three tiers of improvised litter racks accommodating generally 12 patients, rarely as many as 30. Usually in a separate dugout were two rooms for the bathing, emergency treatment and re-clothing of gas cases. The doors of these aid stations were protected by two tight fitting blanket curtains soaked with alkaline solution so adjusted that they would fall into place upon touching a release.

The stations constructed by the Americans themselves were generally less pretentious. The depth was usually 10 to 12 feet, but might be 20. Equipment included at least two Thomas splints, a shock table, two 500 liter oxygen tanks, suits of overalls, gloves and masks for handling gas casualties, fans and sprayers to use in cleaning out the galleries to which gas had penetrated. Those on duty consisted normally of one medical officer, a dental officer if available, and four to six enlisted men, usually supplemented by two runners and one or more litter squads from an ambulance company.

In open warfare provision of necessary supplies and maintenance of contact was difficult. As the troops advanced the battalion aid station moved forward to successive locations, the collecting posts being in hastily dug holes, open fields, shell holes, gun emplacements, cellars, behind ruins and low embankments. The collecting and carrying of the wounded was interfered with by dense brush and forest, barbed wire entanglements, abandon trenches, ignorance of the terrain and the darkness present when removal was safest.

A gas attack meant a sudden overwhelming of the battalion aid station. Everyone would fall in at once in great confusion and excitement. If the cases were those of mustard gas, after proper change of clothing, they could be easily evacuated, since many could sit or even walk; however, chlorine casualties had to be moved recumbent. The medical attendant had to be prepared to do a tracheotomy. Frank gas cases could not be kept with others due to the diffusion of gas from their clothing. The most difficult patients were those who claimed they were gassed, for frequently the surgeon had no means of knowing whether a doubtful condition was one of delayed poisoning or merely of gas fright.

Each division had one to three ambulance dressing stations according to the width and activity of the sector. Battalion aid stations rarely evacu-

ated directly to field or evacuation hospitals. The 42nd Division used its ambulance dressing station as triage. The triage, or sorting station, whence patients were distributed to the appropriate hospitals, represented a setup borrowed from the French and British, generally being a part of, or connected with, a field hospital. By day ambulances seldom could approach nearer than two or three miles of the front, but under cover of darkness they went directly to the battalion aid stations if possible. The headquarters of the ambulance company section was habitually near the field hospital except during active fighting. In trench warfare in advance of the ambulance dressing station were ambulance posts, or "cab stands" as they were familiarly known. As one loaded ambulance passed back another moved forward. Evacuation from the ambulance head took the wounded to the first hospital which could offer proper surgical treatment.

When roads were subject to interdiction fire patients sometimes did not reach hospitals for 18 hours or more, in such cases receiving every attention except surgical intervention. Detention was cut to the minimum to reduce the danger incident to the development of gas forming bacilli and infection in wounds. Surgical intervention within 12 hours was highly desirable, and in the case of extensive wounds essential.

The field hospital in inactive periods was nothing but a small evacuation hospital differing chiefly in portability, position and limitation to emergency work. It was instituted when war was a war of movement with troops changing their position daily. There were grave doubts concerning its value. The evacuation hospital preferably was placed on a spur of a railroad. Roughly there were about 2,000 beds per 25,000 troops. There were special wards and special teams for fracture cases, chest cases, abdominal cases, etc. The problems of the field and evacuation hospitals more than any other units in the medical organization pointed up the great changes that had taken place in war. There had been increase in range of fire, especially of indirect fire, making the reverse slopes of hills no longer safe; visibility had been secured by means of planes and balloons; the Cross of Geneva had been violated and hospitals out of gun range attacked by avions; roentgenology had become a necessity at the front for locating lodged missiles; antiseptics had given way to surgical sterilization by removal of imbedded clothing and dead tissue; shock was better if incompletely understood; many previously fatal hemorrhages were to be avoided by prompt surgical intervention and transfusions.

The wounds were different from what they had been. In the Civil War 90% had been caused by shot of rather large caliber, blunt and soft, traveling at low velocity. The bullets had become deformed, tending to produce besides the punctiform wounds of entrance, lacerations and con-

tusions of the tissues through which they passed. Frequently they had been turned aside on encountering denser structures. Fractures were generally fractures by contact (butterfly fractures), not finely comminuted bursting ones. Later had come the high velocity bullet with the effect of a stiletto. It pierced above everything else; it did not turn aside but went even through bone. If a man didn't get killed he could count on getting well, all that needed to be done in most cases being to put on a first aid dressing and leave the rest to nature. The idea foolishly infiltrated the army that military surgery was becoming a thing of the past.

The high explosive projectile changed all this. The aim was destruction absolute. Where once was seen only a hole in the body, a hole in the arm, a hole in the leg, now was seen the shell of a body, the shell of an arm, the shell of a leg. How messy compared with those clean cut slashes made by weapons properly belonging to ancient times of which Foxworthy had spoken before the State Association at Evansville in 1902:

"Every insurgent in the Philippines was armed with a bolo. This was of iron with a wood or horn handle, and varied in shape and size from a sword to a dagger, and from a corn knife to a meat axe. It was generally a cruder weapon than the Cuban machete, but very effective in close encounters. As it could be concealed beneath the loose jacket, it was more serviceable than a sword or sabre, which was always visible. The kries is a weapon similar to the bolo, but with a wavy edge like a Christy bread knife."

The reception of a large convoy, the distribution and prompt care of the patients was a task of sufficient magnitude to test the efficiency of any organization.

At times hospital trains arrived at Contrereville on short notice or with none at all. Generally, however, the hour of arrival, the number of sitting and lying patients and their classification, were given. Each patient had attached to his clothing his medical card made out at the field hospital giving his name, rank, organization, diagnosis and history in brief. Priority was given the seriously ill who were routed directly to hospital; all others were loaded in ambulances, four lying and eight sitting, and sent to the *Établissement des Eaux*. Bathing before admittance proved to be a great boon.

The Cosmopolitain of 900 beds received *les grandes blessés*, the Paris of 275 beds *les petites blessés*. The wounded went first to the X-ray department for search of foreign bodies. This was in charge of Beeler, assisted by Lochry, the latter taking over while Beeler was away. Lochry was ordered out with a surgical team, being finally transferred to Red Cross Hospital 4, Liverpool. From X-ray the patients went to surgery.

Anaesthesia played an important role. Ether was commonly employed, given by nurses and orderlies under the instruction of a trained medical

anaesthetist. Nitrous oxide and oxygen was the officially approved choice but it was impractical due to shortage of apparatus and the difficulty of quickly teaching the technique, while chloroform as used by the British and French was considered too dangerous. In July, 1918, the hospitals at Contrereville were joined with those of the neighboring town of Vittel. In charge of anaesthesia for the whole Vittel-Contrereville Center was Capt. Arthur E. Guedal, former superintendent of the Deaconess Hospital in Indianapolis. He developed a quick acting mixture for short operations for the general induction of all ether anaesthesias. It consisted of 86 cc. of ether, 23 cc. of ethyl chloride and 2 cc. of chloroform, a dose of from 22 to 30 cc. being sufficient for rapid induction, cutting the time of 20 minutes required for ether alone to 2 minutes. Another novelty was the use of an auscultatory intranasal tube for the administration in head surgery of intrapharyngeal ether.

Soldiers with gunshot wounds—bullet, shell and grenade—furnished most of the surgical patients. A total of 5,719 were cared for with 58 deaths, a mortality rate of 1.14 per cent. Mumford, who had been away in Belgium and then with a surgical team assigned to the French Army at Grandvillier, Oise, on return was designated to organize a fracture service. The number of compound fractures was so great that Miss L. V. Beck who was in charge of dressings had to employ five Dakin carts and crews.

Contrary to what might have been expected the Nose and Throat Department proved to be very important. Not only were there many patients with sinus and middle ear infections incident to life in the trenches, but also almost 6,000 gas casualties. The only measure which had been found of value by the Allied Medical Service was the use of oxygen and watery alkaline sprays. The Germans were employing mixed gases thrown over with shells from trench mortars and heavy artillery; they usually began attack with those causing sneezing and lacrimation, following with the much more noxious mustard gas and phosgene.

"No one has ever witnessed such suffering and distress. . . . With skin burned and discolored, eyes swollen shut, spasms of choking, vomiting and struggling for breath, the lungs literally drowned with their own lung secretions, they writhed in pain until they became unconscious for want of oxygen. . . . The deeply cyanosed or leaden colored face, the quickened respiration and rapid pulse, the restlessness, the constant and spasmodic efforts to expel the profuse, frothy expectoration, was the usual clinical picture during the first two or three days. After that came the secondary stage, when the extensive burns in the throat, bronchial tubes and lungs became infected and began to suppurate. As the necrotic process advanced, large quantities of exudate, consisting of broken-down tissues, tube casts, greenish-gray masses of membrane and sometimes necrotic lung tissue, were thrown off in the bronchial discharge."

In the treatment of these unfortunates Page distinguished himself, his method attracting wide attention and being recommended in the official bulletins of the Allied Gas Service. The first object was to relieve without narcotics the exhausting and ineffective spasms of coughing; the next to promote drainage of the respiratory tract. Best results were found to obtain from application of medicated oils—guaiacol, camphor, menthol in alboline or olive oil, five per cent of each—by tracheal syringe. Cough was produced which expelled large casts from the trachea and bronchi with immediate relief. The camphor-menthol contracted the swollen membranes, the guaiacol acted as local anæsthetic. When spasms were excessive antipyrine was used, while in chronic cases the ulcerating surfaces were treated with silver nitrate or Argylol through a bronchoscope.

A central laboratory was organized in April, 1918, in the Harmond Hotel, subsidiary laboratories being established in other hospitals. Elmer Funkhouser was in charge of the necropsy and microscopic pathology service. He was sent to Dijon for five weeks training in serology, thereafter doing such work for all hospitals.

Major Charles D. Humes became consulting neurologist for the whole Vittel-Contrexeville Center. It was found that the majority of so-called "shell shocks" had been acquired en route from Hoboken. After arrival in France a state of pure old fashioned homesickness had supervened. The English in the first two years had pensioned 90 per cent of their war neuroses; the French had sent 90 per cent of theirs back to the lines. The Americans retrieved most of theirs within two weeks. After forty-eight hours rest these were put on hikes, formed into squads and worked back into duty class. The Chateau-Thierry drive netted the Center 600 such cases; not one came out of the Argonne.

* * *

Wars are not won on the battlefields alone.

One of the first requirements is money. This was raised by the five Liberty Loan campaigns. The next is men. The record made by the profession in investing was better than that in enlisting. Final filling of Indiana's quota in the Medical Reserve Corps came only after much effort. It began to seem that after all the *Journal* was right in its plugging for medical conscription.

The slowness in responding was not entirely due to indifference. There was lack of effective organization in the War Department; the delay in assigning men to active service did not coincide with the insistence that more doctors were needed; many officers were stationed in cantonments for months without receiving a single call for professional service; there was failure in establishing examining boards in the larger cities of the state as promised.

The first call was issued by Eastman January 29, 1918. April 8, Surgeon General Gorgas himself made an appeal.

Figures showed Indiana to rank 42nd in the list of states. To secure the additional 400 enlistments required, a recruiting drive in more than 50 of the counties, winding up with rallies on May 7, "Lusitania Day", was put on by the Indiana Committee of the Council of National Defense. This committee headed by Eastman was composed of representative physicians from all parts of the state: Miles F. Porter and Charles E. Barnett, Fort Wayne; S. A. Clark, South Bend; W. T. Gott, Crawfordsville; George F. Keiper, Lafayette; Charles Marvel, Richmond; Charles H. McCully, Logansport; John N. Hurty, Thomas B. Noble, O. G. Pfaff, Albert E. Sterne, George N. Wells, W. N. Wishard, Frank B. Wynn, C. P. Emerson, W. D. Gatch, John H. Oliver, all of Indianapolis; S. M. Rice, Terre Haute; W. H. Stemm, North Vernon; Edwin Walker, Evansville; G. W. H. Kemper, Muncie; George T. MacCoy, Columbus; and the Surgeon at Fort Harrison. Eastman and several others had gone to Washington May 2. The committee carried on its work through the State Medical Association's office at Indianapolis. Lieut. Col. John H. Allen of the 84th Division, Camp Taylor, sent out a number of his best medical officers to make talks. He himself addressed a meeting of the Indianapolis Medical Society attended by about 250 physicians. Prominent Indiana doctors were assigned to rallying points all over the state to make similar appeals. As a result many enlistments were secured, but still it was not enough. Throughout June, July and August the *Journal* had to keep hammering away:

"In spite of the recruiting rallies . . . it is an undoubted fact that numbers of younger Indiana doctors are holding back . . . their continued lack of response to the call . . . cannot fail to shortly bring upon them the hated term of slacker. We regret to admit that there is still another class . . . which intends to reap as long as possible the golden harvest left ripe for them by the departure for France of their patriotic associates. One member of the Medical Association openly stated that he intended to hang on as long as possible 'while the pickings are so good.' Others like him may lack the audacity to admit such despicable cupidity. . . . A state committee has been appointed to classify the doctors of every county to determine which ones should go first. They will be listed in something like the following groups: Class A, unmarried doctors; Class B, married but with no children; Class C, doctors having dependents whose income is insufficient; Class D, doctors physically unfit or more than 55 years old."

By August maximum pressure had been brought. Those in authority talked tough. It was announced that the Government was about to assume control of the entire profession; that Governor Goodrich was taking steps to "smoke out" those who should have but had not enlisted; that those loudly boasting of patriotism and accusing their confreres of pro-German sympathies would be investigated,

their purchases of Liberty Bonds, contributions to the Red Cross and other humanitarian war activities, carefully scrutinized; that before long the Committee on National Defense was going to publish a list of slackers.

Rather disgracefully several physicians had the presumption to have Albert E. Stern write to Washington protesting that they could not accept the rank or pay for which they had been recommended. Col. Burt W. Caldwell had answered that the personal financial obligations of applicants could not be taken into consideration; that age, previous military experience and professional qualifications must obtain for advanced standing; that as an absolute rule none within draft age could be recommended for commission higher than First Lieutenant, and only exceptionally any one under 35; that the great majority accepted the commissions for which they had been recommended and by faithful performance of duties merited and received their promotion.

Though tardy, the final showing was good. At the Armistice Indiana was among the first ten states, approximately 800 doctors below 55 years, out of about 4,000 eligible, having joined the colors.

The Wells County Medical Society in May, 1918, resolved to bar any "practice jumper," that is any physician established in another location who "jumped" into their bailiwick, from their society. Of this action others approved, asserting that any man taking unfair advantage of the conditions then prevailing was deserving of the severest censure. The tendency of some of the older physicians in the small towns to move to larger ones or to cities was deprecated.

Just before fighting ceased steps were under way to divide the state into districts with the intention of dispatching members of the Volunteer Medical Service Corps to points requiring a physician. The movement to form this organization, composed of doctors more than 55 years of age or incapacitated for active service in the field, had begun in April. The work was in charge of Frank B. Wynn.

The State Association met in Indianapolis September 25, 26 and 27, 1918. Eastman in his presidential address spoke on "Indiana Doctors and the War." This meeting was more devoted to military matters than any that had been held; besides the papers on war questions presented on the regular scientific program, there was a whole evening, open to the public, given over to speeches on war topics.

The State Association and the county societies earlier had taken steps trying to safeguard the interests of those who left. It had been voted that all physicians in good standing should have their state dues remitted and the *Journal* and medical defense protection benefit paid for out of the

general fund. A number of county societies had agreed to apportion the fees collected.

It is probable that it will never be definitely settled where the severe and fatal form of influenza arose in the fall of 1918. The last pandemic had been that of 1889-1890, with small loss of life. There had been minor outbreaks in the winters of 1907-1908, and 1915-1916.

It is estimated that in the United States in the four months of September, October, November and December, 1918, there were 445,000 deaths.

Truly influenza was a killer more to be feared than the German Army, one easily invading the home front, slaying soldiers in cantonment and civilian in his own domicile with equal facility. The problem was one of unparalleled magnitude, and *strictly medical*. The medical men in the army had fretted and fumed at doing military tasks, their function being, they said, to prevent and treat disease. Yet when the great test came they found their science and their art wanting. The army sanitarians and the public health officers were as powerless to prevent the spread of influenza as the divisional physicians and the practitioners at home were impotent to cure it. This was one of the most disgraceful defeats in all history.

That summer was one of troop movements on an enormous scale. Camp after camp sent its trained division abroad, being filled up again with raw recruits. The rates for influenza began to rise early in August increasing progressively to the high point in the fall. Camp Devens, Massachusetts, was the first cantonment to report the highly fatal form. It is supposed to have received the contagion from Boston, where first cases appeared on the naval receiving ship at Commonwealth pier, August 28. Other camps were rapidly and devastatingly hit.

The annual death rate from all causes per 1,000 population in Indiana for the four month period was 20.2 as against 12.9 for the corresponding months of the year before. Of the 56 physicians who succumbed only about half died from influenza. The toll would undoubtedly have been much greater had not many of the more highly susceptible younger physicians been gone. It is remarkable that more did not lose their lives, for by attending influenza patients all day and far into the night they were more exposed to the virus than anyone else. Their loss of sleep was appalling; their exhaustion profound. They were on the go constantly, not being in their offices for weeks. Often they found every member of a family abed, deaths multiple.

The State Board of Health was a little "wobbly" in its decisions, giving county and city boards of health to understand one minute that they must close schools, theaters and churches, and put a ban on all public meetings, the next issuing in-

structions that local boards of health should use their own discretion. Most communities attempted to lock the barn after the horse had been stolen; some who prior had wisely instituted closing measures, listening to the pleas of business men and ministers, rescinded their protective orders to their sorrow. The private practitioners were helpless.

The *Journal* cried out accusingly that the public health authorities, though perfectly cognizant that influenza was epidemic in Europe in a virulent form, had not established quarantine of infected troops and civilians returning from Europe; that convalescents had not been segregated, but allowed promiscuously to be visited by friends and relatives, and to run loose in the streets; that the good accomplished by bans on public gatherings had been largely nullified by total disregard of the necessity of isolating individual patients; that the wearing of masks worn one minute and discarded the next had proved of little use; that the good sense and sound judgment usually characterizing public health work had been absent, the officers seemingly having lost their heads completely, recommending measures that were not only unnecessary but thoroughly inconsistent.

The truth is that the health officers were caught off balance, victims of strategic surprise. They knew of influenza, but not of its deadliness. The public was at fault too, for they had not cooperated by putting public good above private gain and individual license.

* * *

The number of beds in hospitals of the Army in April, 1917, was 9,530, distributed among 131 post hospitals, 4 general hospitals, and 50 base hospitals. Of the large specially constructed Civil War hospitals none had survived. The wave of patriotism at the start led many persons to offer their properties to the War Department for hospital use—lofts, department stores, sanitariums, private establishments, homes. In Indiana the Union Hospital, Terre Haute, through its Superintendent, Charles N. Combs, in the spring of 1917 offered the entire plant to the government. The need at first was for expansion of post hospitals, and to provide hospital facilities at the camps. However, with the return of wounded and diseased from overseas the need for increased facilities to house them became evident.

Efforts of the Medical Department to secure Fort Harrison for general hospital purposes began in May, 1917, but for various reasons were never successful until September 21, 1918, when this post was at last designated General Hospital 25. Plans were prepared for the construction of

a number of temporary buildings which with those already available would have given a bed capacity of 2,500. This expansion, however, was never carried out. The existing buildings were turned over in October, about 1,600 sick being at once admitted. Subsequently to this the number of patients remained at about 900. At first (and later) general medical and surgical cases were treated, but during the winter of 1918-1919 the hospital was employed for the treatment of mental cases, drug addicts, inebriates, epileptics and mental defectives. General Hospital 25 was discontinued September 1, 1919.

General Hospital 35 consisted of the West Baden Springs Hotel with the small Sutton Hotel added for nurses' quarters. The great spa was leased September 28, 1918, effective October 15, at \$125,000 per year, the lease including all of the hotel buildings, the golf course and 620 acres of land. \$123,000 were spent in alterations. There came into existence operating rooms, x-ray, laboratory, eye, ear, nose and throat and dental departments, complete and thoroughly equipped. The medical personnel consisted for the most part of doctors out of state, though Captain J. A. McDonald, Indianapolis, was head of the department of Internal Medicine. Here were ordered many officers from Camp Greenleaf.

The hospital opened on November 2 and by December 7 had 400 patients under treatment, the occupancy remaining about this. The bed capacity was at first 500, being increased to 650, and then to 800. A very complete educational and vocational program was set up. In the great atrium where had frolicked the members of the Indiana State Medical Association in 1913 there were now put on nightly entertainments furnished by the Red Cross, Knights of Columbus and the Post Exchange. March 12, 1919, the Secretary of War authorized abandonment of the hospital, the remaining patients under treatment being disposed of by discharge and transfer at the rate of about 50 each week until April 29. May 8 the hospital was closed.

Such is war. Just as more adequate facilities are created, conflict ends.

The success of Allied arms in the fall of 1918, cheered everyone. Terms of an armistice were presented November 7. Rumor had it that these had been accepted. All over Indiana people stopped work to celebrate. Similar premature rejoicing took place among the American forces in France. By popular acclamation in Contrexeville, Friday afternoon, November 8, marked the end of hostilities. The band was sent to Vittel to join in the celebration parades. Impromptu speeches were made, generally hilarity indulged in. The French, however, were calm. They said that if the report were true, the mayor would have been notified and the town crier spreading the news. When the official word did come November 11 it was Mayor

Morel who got it first, communicating it to Colonel Clark whom he kissed on either cheek in the street much to the Indiana surgeon's embarrassment. A firing squad gave a presidential salute of twenty-one volleys.

Unequivocal word reached Indiana at 2 o'clock Monday morning, November 11. Emotions broke loose unrestrained. Whistles blew and at daylight the people poured into the streets. Schools and business houses closed, everyone joining in the din. Indianapolis celebrated for 24 hours. With night-fall flares were ignited on top of the buildings surrounding the monument, patriotic and religious songs sung with the aid of bands and the chimes of Christ Church.

The task of getting the troops back from France and demobilizing them was immense. The weeks dragged. Those with "32" didn't mind so much till after January 7 when their last 336 patients had been turned over to "31," and all the equipment shipped away. Then the wait became almost unbearable. The older officers were being transferred and sent home. Finally at 4 p. m. February 19, a telegram came that the unit would entrain for Nantes shortly before 6 p. m. the next day.

The population of Contrexeville was at the station to see them off. The trip to the coast was maddening. They had been given part of a train made up of one third-class coach for officers, five for enlisted men, and three box cars for baggage and kitchen. Billeting had been arranged for at St. Sebastien by Captain Moore who with a detail had gone ahead. The men spent the time preparing for the examinations and inspections required before being assigned for return to the United States. Hikes through the country, trips into Nantes where opera could be attended almost any evening, helped break the monotony. March 16 they were joined by the personnel of "31". Most of the officers left for St. Nazaire April 17 from whence they proceeded to Camp Jackson at Columbia, S. C. Those remaining embarked on the U. S. S. *Freedom*, a small German freighter of doubtful seaworthiness, April 13, after having spent seven long weeks in the embarkation area. They were 15 days in crossing to New York being sent first to Camp Mills, then to Camp Merritt, N. J. May 5 Base Hospital 32 entrained for Camp Taylor with that other Indiana unit, the 150th Field Artillery. The train was routed through Indianapolis so that these organizations might take part in the great Victory Parade.

Indiana staged her mammoth welcome-home celebration May 7.

All preparations had been made. All business was at a standstill. The start was announced by noise bombs. The line of march was east on Washington to Alabama, back to Meridian, north on Meridian through the Victory Arch, around the southeast segment of the Circle and east on Market to Pennsylvania, north on Pennsylvania to Ft.

Wayne Avenue, northeast on Ft. Wayne to Delaware, north on Delaware to Sixteenth Street, west on Sixteenth to Meridian, South to the west half of the Circle, through the Victory Arch to Washington, west on Washington to the demobilization point. Special features were the living American flag at the Benjamin Harrison School, the Court of Honor of the Allies, the Caisson ceremony at Ohio Street. Baby tanks rested their camouflaged hulks in front of the Hotel English. The Purdue band headed the procession, followed by an empty caisson drawn by four black artillery horses. As the column approached Victory Arch a veteran of the Civil War and one of the Spanish-American War cut the silken cord stretching across. Maidens standing on pedestals strew the way with flowers. The monument was surrounded with festoons of laurel suspended from white columns tipped with gold. It is said there were present 175,000 to 180,000 people as spectators. It was the most impressive spectacle in the history of the State.

The men of "32" went directly to their waiting train, arriving at Camp Taylor about 9 that night. Saturday, May 10, 1919, every member of the unit was honorably discharged and Base Hospital 32 ceased to exist.

* * *

Though Base Hospital 32 and the 150th Field Artillery were the two largest Indiana units serving through the war there were other smaller outfits. Hospital Unit I, made up of several physicians, 21 nurses and 48 enlisted men was organized at Anderson by John B. Fattic. It was mobilized December 18, 1917, reporting for training to Camp McPherson, Georgia. Sailing for overseas duty March 22, 1918, it took over the British Military Hospital at Hursley, England, later called U. S. Hospital 204. Some of the members were ordered to detached service, the main part of the unit being sent to Langres, France, and amalgamated with Base Hospital 54. Hospital Unit M was organized and equipped in Fort Wayne with Miles F. Porter as chief, consisting of one director, an adjutant, two chief surgeons, four staff sergeants, one head nurse, 20 nurses and 3 clerks. Red Cross Ambulance Company 18 under command of Captain Mason Light, composed of 119 young men from Indianapolis and Broad Ripple left for Camp Grant in September 1917 for training for service in France.

Many Indiana doctors who were not with the distinctively Indiana units served conspicuously. Colonel Victor T. Keene was in command of the General Hospital, Plattsburg Barracks, N. Y., General Hospital 5, Fort Ontario, N. Y., and Base

Hospital 70 in France; Lieut. Colonel Carleton B. McCulloch besides his service with "32" was in command of Mobile Hospital 11 in France; Lieut. Colonel Frederick B. Tucker of Noblesville was commanding officer of Base Hospital 43 and Base Hospital 51 in France; Lieut. Colonel Simon P. Young was commanding officer of the Base Hospital, Camp Gordon, Atlanta; Major John W. Sluss was chief of the surgical division at the Base Hospital at Camp Grant, later chief surgeon at Camp Cody; Lieut. Colonel A. P. Roope of Columbus was head of surgery in Base Hospital 78 in France; Lieut. Colonel Henry O. Bruggeman was with Evacuation Hospital 8; Capt. A. E. Faube, also of Fort Wayne, was in charge of United States Hospital Train 50 in France; Frederick O. Warfel of Indianapolis was Commanding Officer of Camp Hospital 77 in France; Capt. R. L. Sensenich of South Bend, with the base hospital at Camp Custer, became chief of the Medical Service in Government Hospital 36 at Detroit; and there were others. Colonel Larue D. Carter served as Division Surgeon of the 39th Division, and after the armistice as Commanding Officer of Base Hospital 30 located at Clermont Serrand. Major Paul Martin, just as he had gone to Europe before America's entry into the war, now after the conflict sailed from New York, July 10, 1919, to be consulting surgeon of the string of Red Cross Hospitals in Russia extending from Vladivostok to Omsk.

As a war measure a majority of the medical colleges of the United States had continued their sessions through the summer months. The Indiana University School of Medicine in 1918 began June 13 and continued till the middle of September. The facilities were taxed to the limit due not only to the fact that many of the faculty had gone to war, but also to the sad state of the school building which had been damaged by fire in December, 1916. Those belonging to the Medical Enlisted Reserve were finally taken into the Students Army Training Corps on an inactive status. They were not inducted till the day after the Armistice. Housed in the Morton Hotel on Monument Circle, they were allowed only two hours a day for study, the rest of the time being taken up by army routine. A second lieutenant had charge of drilling. Records Thurman B. Rice:

"Medical men never take too well to this drill business . . ., but the day *after* the shooting stops is a *particularly bad* time to start. That silly officer took us north on Senate, east on Ohio Street and then south on Illinois—right through the heaviest city traffic—before we had even learned to do a 'squads right' or turn a square corner. The depths

of ignominy were sounded when a newsboy at Market and Illinois yelled, 'Hey, you darned fools, don't you know the war's over?'"

Yes, the war was over, but not all the fault finding, not the recrimination. There was an occasional ex-Reserve Medical Officer who stood up for the "Service," such as B. M. Edlavitch, Fort Wayne, but by far and large the attitude was that of the resentful critic writing from Evansville, who, averring that of all the fellow victims to whom he had spoken during his two years in the army not one half of one per cent would ever join any Reserve Corps again, said he was going to publish a book entitled, "The Confessions of a Cootie Catcher," dedicated to the Regular Army Medical Corps. This would contain chapters about round pegs in square holes, square pegs in round holes, why politics did not enter the M. R. C., why I stayed home and got a higher rank than the fellows who first volunteered, the tragedy of the small man in the big place, and vice versa, etc. Apologists, however, pointed out that no great undertaking ever escaped censure of one kind or another; that in a country illy prepared, to expand an organization many hundred times in a few weeks or months was a tremendous undertaking making it not surprising that the process should be accompanied by mistakes and inequalities not consonant with the highest type of efficiency. Two things, however, seemed to stand out crystal clear. Concluded the *Journal*:

"With the closing of the great war there has fallen on the shoulders of the American Medical Profession a mantle of grave responsibility to true scientific medicine. Up until very recently . . . we have been wont to look to Europe and not infrequently to Germany and Austria for a signal light along a path of investigation which we desired to pursue . . . Now, however, with western Europe practically pauperized both from financial and intellectual standpoints . . . it is left to America with her abundance of dollars and opportunities for research to bear for a while the burdens of the scientific medical world."

"Finally let us in peace, prepare for war, for we have learned by bitter experience what it costs to be unprepared for a war that could have annihilated us had we been fighting alone."

* * *

Man, though afraid, courts peril; seeks adventure; wills to dominate. Besides cooperation, he, in his society, practices conflict. So it has always been, so it will always be. In spite of his hope and need that strife no longer take the form of armed combat between sovereign powers, there still is war.

IX

Part Three

INDIANA DOCTORS AND WORLD WAR II

CHARLES F. THOMPSON, M.D.*

THE participation of the medical profession of Indiana in the national emergency following the attack on Pearl Harbor was three-fold: First the execution of a plan of allocation of physicians to the armed forces, which was initiated by the appointment of a Medical Preparedness Committee by the State Medical Association in 1939; Second—the individual accomplishments of doctors in the Services which varied from the dreary routine in posts far from theatres of actual combat to outstanding acts of heroism, devotion to duty and demonstration of professional skill to a degree characteristic of the response of free-thinking men to a highly critical environment; and Third—crippling injuries and wounds by many, and the ultimate sacrifice by 14 doctors from Indiana in service, that of life itself.

The Medical Preparedness Committee of the Indiana State Medical Association was one of the first of such state committees in the country. It is to the credit of this committee and its chairman, Dr. C. R. Bird, that the groundwork was done leading to the accomplishment of Procurement and Assignment Service in Indiana. Such service, including committees in each county, was effective in allocation and recruitment of more than nine hundred physicians from civilian practice to the Armed Forces at the end of the first year of war. The problem of equable distribution of remaining doctors throughout the state was one of tremendous importance.

More than 1200 physicians served on Selective Service Boards in Indiana during the period 1942-45. This voluntary service was one which entailed long hours spent in examining registrants for military duty, time spent beyond their already increased daily duties.

The voluntary and part-time teachers serving Indiana University Medical Center during the war time program of twelve months instruction to medical students was carried on by a faculty depleted by loss of men in the Army and Navy. Emergency night calls were answered by voluntary doctors, many of whom had physical handicaps which prevented them from entering military service. Particular mention should be made of that group of doctors in Indiana, veterans of World War I, whose age prevented them from active duty again but whose desire to serve in another war was necessarily diverted into unending effort to supplant the temporary loss of younger men on active duty. In such manner the obliga-

tion of the medical profession to the citizens of Indiana was fulfilled on the "Home Front" during the trying years of 1942-45. To no less degree did the public make sacrifices in recognition of the doctor shortage that some 1300 physicians might serve the armed forces in training and in war theatres.

The state of Indiana may be justly proud of the attainments of native Hoosiers who chose the Army and Navy for their medical career. In Medical Training Centers, Aviation Medicine, both Army and Naval Hospitals, and associated research centers as well as Theatres of Operation during the war, these men were found at the highest level of command. In the service which has taken them to every part of the globe they are apt to be lost from the annals of Hoosier medicine. It is quite proper, now, to include them as the peers among doctors in active service during World War II. No glow of superlatives can add to the record of Hawley as Surgeon of a Theatre, Duckworth in General Hospital I on Bataan, Hildrup in making central Africa safe for the Air Force, Armstrong in the Medical Training Center at Camp Barkley in Texas, and Longfellow at Walter Reed Hospital.

In the Navy there was Wilcuts as a surgeon and in command of hospitals, Newhauser in research and training medical officers, Wickstrom as an otolaryngologist, Payton as a roentgenologist as well as Zearbaugh, Wright and Chessser with enviable records. The names of these men constitute a galaxy.

Within the first few months following December 7th, 1941, Reserve Officers of both the Army and Navy left civilian circles. Graduates of succeeding classes from Indiana University School of Medicine made a total of almost 300 in this group. Years of Reserve training and rank by virtue of such service soon gained command levels for many of these men. There were Bowers and Stout, who had served during World War I, Clevenger, Maurice Glock, Owsley, Booher, Stevens, Halleck, Morris Thomas, Pfaff and Sweet who became commanding officers of hospitals, or unit surgeons. From the Naval Reserve MacKenzie, List, Day, Phillips, Hall, Hayes and Bibler attained high rank and command. The younger group of Reserves having company and junior grade level saw service in all Theatres at duty which called for skill and durability of the highest degree. They, too, served well.

There were 26 physicians mobilized with the 38th Division in the early months of 1941. These

* Indianapolis. Veteran of World Wars I and II.

constituted the Medical Regiment of the Division. From this group of experienced medical officers Sluss and Keeling rose to the command of hospitals in foreign theatres, Hallam became a Corps Surgeon, Ramsey a Division Surgeon, Howell a Battalion Commander, Greer, Griest and Jobs Area Consultants—all of whom served with distinction.

The 32nd General Hospital sponsored by Indiana University School of Medicine, to succeed Base Hospital 32 in World War I, was organized late in 1941, mobilized in January of 1943 and functioned in England, the invasion of Normandy, and was the first general hospital to serve in Germany—at Aachen. Thirty-nine doctors from the entire state staffed the Hospital, the largest unit of doctors leaving Indiana. It was commanded by Clark with Cheney and Thompson as chiefs of Medical and Surgical Services. From the professional staff of the 32nd two-thirds of the officers were advanced as chiefs of Specialty Services in other similar hospitals and two served in like capacity in the Pacific Theatre after V. E. Day. For service to 35,000 casualties there was commendation from the Theatre Commander and Surgeon.

By July of 1942 some 700 more doctors received commissions in the Army, Navy and Air Force. These men, without previous military service, but by the exercise of stability of character, professional skill, ingenuity and initiative served in all Theatres and returned at the end of hostilities with decorations for service in all battle engagements. The individual military rewards of such men—in many instances lost to the War Department by enemy action in the field and at sea—remain in the memory and heart of each as a source of personal pride for a task well performed. John Owen, Orval J. Miller, Collip, Iske and D. L. Smith became Hospital Commanders in this group. Individual instances of heroic service have become public record.

There were accidents, casualties and disabling illness to some of these men. Many were invalided or retired from service; others survived and resumed duty until the end of the war. Maris of Attica sustained the most crippling wound from action in contact with the enemy in the Pacific Theatre. James Duckworth, Nelson Kauffman, Thomas Hewlett, Basil Dulin and Harry Brown survived as prisoners of the enemy in the Pacific Theatre. Brown met accidental death shortly after completion of resident training.

THE HONOR ROLL OF INDIANA DOCTORS IN WORLD WAR II

Lt. Emil Nicholas Kveton of Fort Wayne, who entered the Medical Corps of the United States Naval Reserve January 1942, was killed in action at sea on August 9, 1942. *Lt. Kveton* was the first Indiana physician killed in action during

World War II. He was 29 years of age and a graduate of the Loyola University School of Medicine, Chicago, in 1938. He was a member of the Indiana State Medical Association, the American Medical Association and the Fort Wayne Medical Society.

Lt. John Francis Kerr, Jr., of Indianapolis, who entered the Medical Corps of the United States Army early in 1942, died at El Paso, Texas, on August 18, 1942, from injuries suffered in an accident when he fell beneath a moving train. He was 35 years of age and had practiced medicine in Indianapolis for ten years prior to his induction into the armed forces. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association. He was a graduate of the Indiana University School of Medicine in 1930.

Capt. John Elliott Carter, United States Army, died in military service in the Southwest Pacific Peru, South America, September, 1943. He was in practice in Richmond. He graduated from the Western Reserve University Medical School, Ohio, in 1938; interned at the Methodist Hospital, Indianapolis, served a residency in pathology at the Ball Memorial Hospital, Muncie, and Methodist Hospital, Indianapolis.

Capt. Robert C. Badertscher of Bloomington, Indiana, died in an army bomber crash at Iquito, Peru, South America, September 1943. He was a graduate of the Indiana University School of Medicine in 1940. He was a member of the Monroe County Medical Society, the Indiana State Medical Association and the American Medical Association.

Lt. Kurt B. Klee, Indianapolis, was killed in action in the North African area on July 10, 1943. He was commissioned a 1/Lt. in the Medical Reserve Corps, United States Army, September 19, 1941; began extended active duty on April 10, 1942, being assigned to the Aviation Cadet Board in Boston, and served with the Paratrooper Division. He was posthumously awarded the Purple Heart on October 5, 1943. He graduated from Indiana University School of Medicine in 1940. He was 30 years of age.

Capt. Harry D. Miller, Shelbyville, was killed in an accident while serving with the United States Army Medical Corps in Algeria on February 2, 1944. He left Shelbyville May 15, 1942, was the second Shelbyville physician to enter the service in World War II. *Capt. Miller* was a graduate of the University of Illinois College of Medicine, Chicago, 1934. He was a member of the Shelby County Medical Society, the Indiana State Medical Association and the American Medical Association.

Lt. Comdr. Marlin P. Smith, Muncie, Indiana, age 30, was killed in an automobile accident in North Africa on July 5, 1944. He was the first Muncie physician to volunteer his services in World War II. He was a member of the Delaware-

Blackford County Medical Society, the Indiana State Medical Association and the American Medical Association, and a diplomate of the American Board of Otolaryngology.

Col. Frank Bolles Wakeman, United States Army, formerly of Valparaiso, Indiana, died March 17, 1944. He was chief of the Training Division of the Office of the Surgeon General. He was born May 15th, 1896, and graduated from Indiana University School of Medicine in 1926.

Maj. Michael A. Rafferty, Elkhart, assistant medical director of Miles Laboratories, was killed in action in Belgium, November 24, 1944. He graduated from Rush Medical College, Chicago, 1937; formerly associated professor of biochemistry at the West Virginia University School of Medicine, Morgantown, W. Virginia. He was commissioned a captain in the medical corps, Army of the United States, June 2, 1942. He was 40 years of age. He was a member of the Elkhart County Medical Society, the Indiana State Medical Association.

Maj. Gordon H. Haggard, Hope, age 36, who was listed as missing in action over Germany October 7, 1944, was listed as dead by the War Department October 15, 1945. Graduate of Butler University and Indiana University School of Medicine in 1933. He was a member of the Bartholomew County Medical Society, Indiana State Medical Association and American Medical Association.

Capt. Robert B. Miller, age 35, of Argos, died April 20, 1945, at the Percy Jones General Hospital from injuries received in the European Theatre of Operation. Capt. Miller graduated from the Indiana University School of Medicine in 1934, entered active military service in 1940, served with the 4th Infantry Division landing in Normandy on D-day and was evacuated as a casualty from

the Hurtgen Forest. He was the recipient of the Bronze Star Medal and Purple Heart. He was a member of the Marshall County Medical Society, Indiana State Medical Association and American Medical Association.

Capt. Charles D. Clark, age 35, of South Bend, died April 28, 1945 as the result of a Japanese plane attack on the U.S.S. *Comfort*, a naval Hospital Ship. Capt. Clark graduated from Wayne University College of Medicine in Detroit in 1939, entered military service in July 1942 and served in the Pacific Theatre in Hawaii and Australia. He was a member of the St. Joseph County Medical Society, Indiana State Medical Association and the American Medical Association.

Dr. Lawton Shank, Angola, killed while a Japanese prisoner after capture on Wake Island, was a civilian doctor with a construction company and a graduate of Indiana University School of Medicine in 1938.

DIED AFTER END OF WAR

Col. James W. Duckworth, age 55, died of heart disease December 26, 1945, a member of the regular Army Medical Corps since 1917, graduated from Indiana University School of Medicine in 1912, practiced in Indianapolis 1912-17, and was taken prisoner by the Japanese as Commanding Officer of General Hospital No. I on Bataan. He was a member of the American College of Surgeons, Indianapolis Medical Society, Indiana State Medical Association and the American Medical Association.

For these who sacrificed their lives and those who survived battle fronts a spokesman might say: "If it be life that waits I shall live forever unconquered, if death, I shall die at last strong in my pride and free." (Scottish-American War Memorial, Edinburgh.)

X

WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

MRS. FRED S. CUTHBERT*

IN THE early records of the Woman's Auxiliary to the American Medical Association, we read that during a meeting of the Southern Medical Association in Dallas, Texas, Mrs. John O. McReynolds was hostess for the wives of the members and that she asked a guest how she liked Dallas. The guest replied, "Very much, indeed. I have lived here thirty years."

Before the State Medical Association of Texas met in Dallas in May, 1917, the wives of physicians there felt the need of a cooperative social effort.

Mrs. McReynolds called them together, suggesting that they form an organization. This met with a ready response and the Woman's Auxiliary to the Dallas County Medical Society was formed with Mrs. McReynolds chosen president. The slogan was, "Our husbands, our homes, our communities, our country."

In 1918, during the meeting of the State Medical Association in San Antonio, the Woman's Auxiliary to the Texas State Medical Association was formed. Mrs. E. H. Cary of Dallas was elected its first president.

This venture proved so successful that, in 1922, Mrs. Samuel Clark Red of Houston, then complet-

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ing a two year term as state president, conceived the idea of a national auxiliary, and voiced it during the annual state meeting in El Paso. She was encouraged and then empowered to present a resolution to the House of Delegates of the American Medical Association soon to meet in St. Louis, Missouri.

The resolution read:

"The Woman's Auxiliary to the State Medical Association of Texas respectfully requests the approval of the American Medical Association of a movement to organize a Woman's Auxiliary to the A.M.A., the object of which Auxiliary shall be 'To extend the aims of the medical profession through the wives of doctors to the various woman's organizations which look to the advancement in health and education, to assist in entertainment at all medical conventions, to promote acquaintanceship among doctors' families so that closer fellowship may exist.'"

In May, 1922, during the convention of the American Medical Association in St. Louis, this resolution was brought before the House of Delegates by Dr. E. H. Cary of Dallas; it was approved. A meeting was held and Mrs. S. C. Red was elected president. The following year, June, 1923, Mrs. Red presided at the first annual meeting, in San Francisco, during the convention of the American Medical Association, with sixty women from seventeen states answering the call to order.

Indiana came early into the picture. In 1924, Dr. Frank W. Cregor, Indianapolis, was reading the *Journal of the American Medical Association*; he said to Mrs. Cregor: "I just read in the *Journal* that the wives of physicians have organized some kind of an auxiliary and that they are holding a meeting during the convention of the A.M.A. in Chicago. All wives are invited to attend. You might see what it is. Such an organization could be a great moral force."

Mrs. Cregor attended sessions at the Edgewater Beath Hotel; she reports: "I was welcomed. I represented a state from which no response had been received. The workers counted each state zealously. I learned that this Auxiliary idea had been approved by the House of Delegates in 1922 during the convention in St. Louis. Mrs. William S. Tomlin and I had attended the St. Louis convention but heard nothing about a Woman's Auxiliary to the American Medical Association. In 1923, I had been in San Francisco but heard nothing about this organization. The 1924 convention was a revelation to me! Mrs. Red presided. Through their representatives, twenty-two states answered roll call; I heard of varied activities and observed much enthusiasm. Members were urged to aid in doubling the circulation of the year old publication, *Hygeia, the Health Magazine*, and numerous means were suggested to increase the readers of this gospel of Disease Prevention and Health Promotion. In his address, I heard Dr. George E. Vincent, president of the Rockefeller Foundation, dwell upon the fact that 'physicians' wives are the connecting links between the profession and the public.'"

In 1925 the convention of the American Medical Association was held in Atlantic City. Four Indiana women registered: Mrs. Albert E. Bulson, Fort Wayne; Mrs. Sam Kennedy, Shelbyville; Mrs. Ralph S. Chappell and Mrs. Frank W. Cregor, Indianapolis. Twenty states responded to roll call. A national chairman of Organization was appointed.

In September, 1925, the House of Delegates of the Indiana State Medical Association approved the report of the chairman of Legislation, Dr. Frank W. Cregor; this report included a recommendation for the approval of an organization of a Woman's Auxiliary to the Indiana State Medical Association.

Before the actual organization of the state Auxiliary, a "Ladies Auxiliary of the Indianapolis Medical Society" was formed at the call of A. S. Jaeger, president of the Indianapolis Medical Society at the Indianapolis City Hospital, October 22, 1926. Mrs. Charles F. Voyles was elected president of the new organization, a wise choice as future events showed.

1927. On September 28, 1927, the Woman's Auxiliary to the Indiana State Medical Association had its organization meeting during the 78th annual convention of the Indiana State Medical Association, at the Woman's Department Club of Indianapolis.

The Woman's Auxiliary to the Indianapolis Medical Society was hostess for the event, which was attended by about two hundred physicians' wives. An address of welcome by Mrs. Charles F. Voyles and an original playlet "Introducing the Auxiliary," written by Mrs. Charles McNaull, gave a "gracious start to the new organization." Elected at the time were Mrs. F. W. Cregor, president; Mrs. W. R. Davidson, Evansville, president-elect; Mrs. A. C. Clauser, Delphi, secretary; Mrs. O. T. Scamahorn, Pittsboro, treasurer.

Mrs. Cregor left the session ready to preach "Auxiliary" everywhere. She needed her faith and enthusiasm; Doctor Cregor advised, "Don't go where you are not invited!" She wrote many letters and awaited invitations. In October, an invitation came from Anderson where, with the support of Dr. M. A. Austin, the Woman's Auxiliary to the Madison County Medical Society came into being. In November the members of the Vigo County Medical Society invited wives to a dinner meeting and a Woman's Auxiliary was organized in Terre Haute.

1928. Carroll and Delaware Counties became organized in April, 1928.

In May of 1928, a Constitution and By-laws were prepared, in accordance with the ideals and practice of the national organization. In its subsequent growth the state Auxiliary has been so closely linked with the Woman's Auxiliary to the American Medical Association that it is impossible to separate their activities; the program of the national officers and events at the annual conven-

tion have each year provided the inspiration for the state to carry through. The full story of the interplay between nation and state is yet to be told.¹

The first annual convention of the Woman's Auxiliary to the Indiana State Medical Association was held in September, 1928, in Gary. Mrs. Gregor presided. Reports were read by officers of the five organized auxiliaries; the Constitution and By-laws were adopted. A guest speaker, Indiana-born Mrs. Morris Fishbein of Chicago, told how the organized wives of physicians were helping their husbands in directed services (even bringing about better attendance at medical meetings!). She named states in which Auxiliary members aided in collecting historical data, surveying public sentiment toward better sanitation and hospitalization, helping in the passage of medical practice Acts, placing primers on prevention of tuberculosis in rural schools, giving assistance to the Medical Benevolence Fund. Particularly did she recommend health talks before all sorts of women's clubs.

That socialized medicine was recognized as a threat then is evident from the talk of the other guest speaker, also Indiana-born, Mrs. G. Henry Mundt, president of the Woman's Auxiliary to the Illinois State Medical Association. "Many well-informed doctors and medical editors feel we are on the threshold of State Medicine, and this would be disastrous to both the profession and public alike." Her suggestion was to spread accurate news about medical legislation.

Further concrete works were suggested by Mrs. Gregor: to read editorials in the state *Journal*; to invite physicians to address auxiliaries in subjects of distinct appeal, or to have a joint program with the local medical society; to acquire knowledge of preventive medicine; to spread allegiance to *Hygeia*, the *Health Magazine*, and *Healthylend*, a book for children. Along with all this she spoke in favor of philanthropy, recreation and fun.

Officers were unanimously accepted: Mrs. M. A. Austin, Anderson, president-elect; Mrs. Edgar F. Kiser, Indianapolis, secretary; Mrs. Everett Zarling, Terre Haute, treasurer.

Before the close of her presidency Mrs. Gregor compiled a twenty-page booklet, *Report of the First Meeting of the Woman's Auxiliary to the Indiana State Medical Association*.

In late October, 1928, at the invitation of Dr. E. E. Padgett, Councilor of the Seventh District, a district auxiliary was organized in Martinsville.

1929. Mrs. W. R. Davidson, Evansville, assumed office as state president in January. In January, also, Vanderburgh County became organized under the initiative of the Medical Society there. A January dinner meeting in Indianapolis, under the spon-

sorship of the Woman's Auxiliary to the Indianapolis Medical Society, honored Private John R. Kissinger, a hero of the yellow fever scientific research experiment in Cuba in 1900, under Major Walter Reed, M.C., U.S.A. A beautiful testimonial was given him in the name of the many cooperating organizations. Mrs. Kissinger was introduced; all knew of her devotion to her husband during the years when he was a victim of paralysis of the legs and was forced to crawl about his home on leather pads.

In the June issue of the *Journal* we read of the May 5th Executive Board meeting of the Indiana Auxiliary. Among other matters at this time there was brought to the attention of those present, the story of Jane Todd Crawford, pioneer heroine of surgery, patient of Dr. Ephraim McDowell, the "Father of Ovariectomy," who is buried in Indiana, near Sullivan. The Kentucky Medical Association and its auxiliary have plans to memorialize Mrs. Crawford.

The second annual meeting was held in September, 1929, in Evansville at the Hotel McCurdy, Mrs. Davidson presiding, 172 members present. Dr. Arthur J. Cramp, director of the Bureau of Investigation of the American Medical Association, gave an illustrated lecture under the alluring title, "Mrs. Gullible's Travels in Cosmetic Land." It was agreed that physicians' wives in counties not yet organized might become members-at-large. Mrs. Davidson formally requested of the House of Delegates of the Indiana State Medical Association that an Advisory Council be appointed for the Auxiliary (the Bureau of Publicity of the Indiana State Medical Association was shortly afterward so designated). New officers were elected and introduced: Mrs. W. S. Tomlin, Indianapolis, president-elect; Mrs. W. C. Moore, Muncie, secretary; Mrs. A. E. Newman, Evansville, treasurer. Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, was one of the speakers.

1930. The third annual meeting was held September 24-25, 1930, in Fort Wayne, with Mrs. M. A. Austin of Anderson, state president, in the chair. Dr. A. E. Bulson of Fort Wayne, editor of *The Journal of the Indiana State Medical Association*, was the guest speaker. He suggested constructive programs. Mrs. J. C. Carter spoke in behalf of placing *Hygeia* in schools and libraries. Mrs. A. C. Clauser of Delphi was chosen president-elect; Mrs. J. E. Freed of Terre Haute, secretary; and Mrs. W. E. Barnes, Evansville, treasurer. Membership was reported as 400.

1931. The fourth annual meeting of the Indiana Medical Auxiliary was held September 23-24, 1931, at Indianapolis, Mrs. Wm. S. Tomlin presiding. After the annual breakfast and business meeting a talk was given by Dr. Miles F. Porter of Fort Wayne, who stated that the Auxiliary was the helping hand of the profession. Dr. W. N. Wishard suggested that the Women's Auxiliary and the

¹ Mrs. Frank W. Gregor, in an unpublished account of her work in both state and national auxiliaries, has written of the enthusiasm in these early years and tells of the many activities suggested then that are being developed today.

Indiana State Medical Association cooperate with the Kentucky State Medical Society in honoring the name of Jane Todd Crawford, pioneer heroine of surgery; honor also the name of Mrs. Mary E. Burnsworth, who was operated by Dr. John S. Bobbs for gallstones, this being the first operation in the world of its kind.

New officers chosen were: president, Mrs. L. E. Fritsch, Evansville; president-elect, Mrs. O. O. Alexander, Terre Haute; secretary, Mrs. J. C. Armington, Anderson; treasurer, Mrs. C. F. Voyles, Indianapolis.

Dr. Edward Henry Cary, president-elect of the American Medical Association, spoke at the annual banquet, the same Doctor Cary who had introduced the resolution in 1922, at the St. Louis meeting, which resulted in creating the Woman's Auxiliary to the American Medical Association.

1932. The fifth annual meeting was held September 27-28, 1932, in Michigan City. Trips were made to the Indiana State Prison and to the asylum for the criminal insane. After the business meeting and breakfast Mrs. L. E. Fritsch, Evansville, state president, introduced the national president, Mrs. Walter Jackson Freeman of Philadelphia.

Mrs. William E. Tinney, Indianapolis, read a resolution expressing to the Kentucky Auxiliary a wish to assist them in jointly honoring the name of Mrs. Jane Todd Crawford, pioneer heroine in surgery. Another famous case in medical history was discussed and the following resolution was passed: "Whereas Dr. John S. Bobbs, Indianapolis, performed the first operation for the removal of gallstones in 1867 on an Indiana woman, Mrs. Mary Burnsworth; and whereas, she was presented in 1905 to the American Medical Association, convening in Portland, Oregon, therefore, the Indiana State Auxiliary desires to cooperate with the National Auxiliary in honoring Mrs. Burnsworth."

Officers elected were: Mrs. I. N. Trent, Muncie, president-elect; Mrs. Charles F. Voyles, Indianapolis, vice-president; Mrs. R. L. Compton, Osgood, recording secretary; Mrs. Charles N. Combs, corresponding secretary; Mrs. U. G. Poland, Muncie, treasurer.

1933. Mrs. Charles F. Voyles presided at the breakfast and business meeting September 26, 1933, given by the members of the Indiana Auxiliary at French Lick Hotel. Dr. E. E. Padgett gave the greetings. Some important activities of the Auxiliary this past year were the organization of Orange County; the unveiling and dedication of a twenty-ton boulder bearing a bronze tablet, the gift of the Indianapolis Woman's Auxiliary; co-operation with the City Park Board in Indianapolis in landscaping the grounds surrounding the City Hospital and the planting of the avenue of elm trees between the City and Riley Hospitals to be known as "Memory Lane," a memorial to the physicians of Indianapolis.

The following officers were elected: president-elect, Mrs. E. D. Clark, Indianapolis; vice-presi-

dent, Mrs. R. L. Compton, Osgood; recording secretary, Mrs. Fred B. Wishard, Anderson; corresponding secretary, Mrs. Frank M. Gastineau, Indianapolis; treasurer, Mrs. U. G. Poland, Muncie.

1934. The seventh annual meeting of the Indiana State Auxiliary was held in Indianapolis, October 9-10, 1934, Mrs. I. N. Trent, Muncie, presiding. Dr. Thurman B. Rice was the guest speaker, discussing diets for children and adults, advising simplicity of living to give good health. The best things in life cost little: sunshine, fresh air, plenty of sleep and simple food. A genuine health program is a happy one, he declared.

Mrs. Frank W. Cregor, still a very enthusiastic auxiliary member, told of the national convention at Cleveland. She reported that 36 states answered roll call, also that guests were present from the Philippines, Sweden, Asia, British Columbia.

A history of the Woman's Auxiliary to the American Medical Association, "The First Twelve Years" by Mrs. Willard Bartlett of St. Louis, was published in pamphlet form this year.

The following officers were elected: president-elect, Mrs. R. L. Compton, Osgood; vice-president, Mrs. Marcus Ravdin, Evansville; recording secretary, Mrs. E. O. Nay, Terre Haute; corresponding secretary, Mrs. John Eberwein, Indianapolis; treasurer, Mrs. C. F. New, Indianapolis.

The Auxiliary members were guests at the beautiful Foster Hall on the J. L. Lilly estate for a musical program. The entertainment was delightful. All of the county units were represented. Some have nothing but social meetings during the year while others are cooperating with hospitals and community services, serving and making gift donations. This makes the community better acquainted with the medical profession and hospitals.

One board meeting was held and well attended. It was voted to print a year book.

1935. The eighth annual meeting was held October 9-10, 1935, Gary, Indiana, Mrs. E. D. Clark, presiding. Mrs. George Dillinger gave a splendid report on the national convention held in Atlantic City. Mrs. Clark had reported there that an all-day Health Conference had been started by Mrs. W. E. Tinney.

Mrs. Roger N. Herbert, Nashville, Tenn., national president, was the guest speaker. It was recommended and approved that two more vice-presidents be added to the staff. Mrs. O. G. Pfaff read a letter from Dr. W. N. Wishard in which he gave a history of the pioneer doctors and their heroic patients. He suggested that it would be a nice gesture for the ladies of the Auxiliary to organize a pilgrimage to these graves, the ultimate object being to secure adequate monuments. A committee was appointed at this time to take care of this work.

Officers were elected as follows: president, Mrs. R. L. Compton, Osgood; president-elect, Mrs. Marcus Ravdin, Evansville; vice-presidents, Mrs.

F. B. Wishard, Anderson, and Mrs. M. B. VanCleave, Terre Haute; recording secretary, Mrs. William E. Tinney, Indianapolis; corresponding secretary, Mrs. James C. Carter, Indianapolis; treasurer, Mrs. Clarence L. Bock, Muncie.

1936. On October 6-7, 1936, the ninth annual meeting was held in Indianapolis. Mrs. Randolph L. Compton, Osgood, president, reported the establishment of a loan fund for the education of doctors' children or medical students.

Dr. Charles P. Emerson, dean of the Indiana University School of Medicine, gave an address: "What Can The Woman's Auxiliary Contribute to the Practice of Medicine." He said a wife could be a great help to the physician if she possessed an understanding of his duties and activities; in seeing that his home life was quiet, being in sympathy with his hobbies. He suggested that the older members of the Auxiliary dress less formally so that the younger ones might not feel embarrassed.

Mrs. Compton announced the appointment of a committee to have charge of the marking of the graves of the pioneer doctors and their heroic patients: Mrs. O. G. Pfaff, chairman; Dr. and Mrs. W. N. Wishard, Mrs. E. D. Clark, Mrs. Fred Wishard and Mrs. W. S. Tomlin. This committee was to be known as "The Pioneer Memorial Committee." Mrs. Pfaff reported one meeting of the committee with Dr. Wishard; that they visited the graves and made pictures of them. They learned that Dr. John Lambert Richmond, who died in Covington, Ky., and was buried there October 12, 1855, had been reinterred in Spring Valley Cemetery, West Lafayette, Lot 45, Section 18, on May 6, 1893. This memorial committee is to work in cooperation with a like committee from the Indiana State Medical Association to memorialize four Indiana medical pioneers:

1. At Sullivan, Mrs. Jane Todd Crawford, who submitted to the first operation in the world for ovarian tumor, the operation being performed in 1809 by Dr. Ephraim McDowell.

2. At Spring Valley Cemetery, Lafayette, John Lambert Richmond, M.D., who performed the first Caesarean section west of the Alleghany Mountains.

3. At Indianapolis, John Stough Bobbs, M.D., who performed the first gallstone operation in the world; and

4. At Oaklandon, Mrs. Mary E. Burnsworth, the patient of Dr. Bobbs, who submitted to the above operation.²

It was suggested (and the suggestion approved) that in addition to the marking of the graves, suitable bronze tablets should be placed in the Indiana State Library and Historical Building, and mark-

ers be placed on the highways to commemorate these historical medical spots in Indiana.

Officers elected were as follows: president-elect, Mrs. Fred B. Wishard, Anderson; first vice-president, Mrs. Maurice B. VanCleave, Terre Haute; second vice-president, Mrs. Henry S. Leonard, Indianapolis; recording secretary, Mrs. Alfred Ellison, South Bend; corresponding secretary, Mrs. Herman Baker, Evansville; and treasurer, Mrs. Clarence L. Bock, Muncie.

Nominations were made from the floor in order to fill offices of the third and fourth vice-president provided for at the previous year's meeting by an amendment to the Constitution. Mrs. James W. Baxter, Jr., New Albany, and Mrs. R. M. McDonald of Mishawaka, were elected to fill the new offices.

1937. The tenth annual meeting was held at French Lick, October 4, 1937, with Mrs. Marcus Ravdin, Evansville, presiding.

Dr. Paul Teschner, assistant director of the Bureau of Health and Public Instruction of the American Medical Association, gave a much enjoyed talk on "The Doctor's Wife." A general discussion followed concerning the organization of more auxiliaries and a better cooperation with the Medical Association. The members were again urged to help to educate the public by keeping themselves acquainted with current medical problems, endeavoring to put them before the women of the community, in the women's organizations, high schools, etc., and by promoting the sale of *Hygeia*.

Wabash and Dubois County were reported as organized.

The following officers were elected: president-elect, Mrs. Maurice B. VanCleave, Terre Haute; first vice-president, Mrs. C. E. Cottingham, Indianapolis; second vice-president, Mrs. Joel Whitaker; third vice-president, Mrs. James Baxter, Jr., New Albany; fourth vice-president, Mrs. H. C. Knapp, Huntington; recording secretary, Mrs. John Habermel, New Albany; corresponding secretary, Mrs. C. V. Rozelle, Anderson; and treasurer, Mrs. Clarence E. Bock, Muncie.

On November 10, 1937 the Indianapolis Auxiliary had a "Hobby Fair" (reported in *The Indianapolis Star* of the day following).

1938. The Woman's Auxiliary to the Indiana State Medical Association held its eleventh annual meeting October 5, 1938. Mrs. Fred B. Wishard, Anderson, presided.

A talk was given by Dr. Norman Beatty, Indianapolis, chairman of the Committee on Public Policy and Legislation of the Indiana State Medical Association. He asked the aid of the auxiliary members in facing the present social and economic problems and urged the members to attend the different lay organizations with the idea of presenting medical education to these groups: to fight socialized medicine, stress the disadvantage for the public welfare, insist that individuals should have the right to select their own physician.

² *The Indianapolis News*, July 11, 1936 and *The Indianapolis Sunday Star*, September 1, 1940 published full accounts of the doctors and their patients.

Mrs. O. G. Pfaff stated that the road signs for marking graves of Mrs. Jane Todd Crawford, Mrs. Mary Burnsworth and Dr. John Lambert Richmond will soon be erected.

The reports from the county chairmen showed an increase in activities and a closer contact between the state and county auxiliaries. The president, Mrs. Wishard, reported that she had visited each organized county. She also reported educational programs, donations of books to hospitals, tuberculosis camps and childrens' libraries; *Hygeia* subscriptions had increased.

Mrs. Frank W. Cregor, our first state president, was introduced and spoke of the value that a physician's wife could be to the public.

Officers elected were: president-elect, Mrs. W. E. Tinney, Indianapolis; first vice-president, Mrs. M. J. Thornton, South Bend; second vice-president, Mrs. C. V. Rozelle, Anderson; third vice-president, Mrs. Charles T. Willis, Evansville; fourth vice-president, Mrs. George W. Seward, North Manchester; recording secretary, Mrs. James W. Baxter, Jr., New Albany; corresponding secretary, Mrs. Charles N. Combs, Terre Haute; treasurer, Mrs. Clarence L. Bock, Muncie; councilor, Mrs. Charles F. Voyles, Indianapolis; and historian, Mrs. U. G. Poland, Muncie.

1939. The twelfth annual breakfast and business meeting was held October 11, 1939 in Fort Wayne, with Mrs. Maurice VanCleave of Terre Haute, state president, in the chair. The "Collect," written by Mrs. H. A. Ray, president of the Allen County Auxiliary was read in unison. Fort Wayne, the youngest of the ten auxiliaries, was reported organized May, 1939.

Dr. Edgar F. Kiser of Indianapolis gave a brief sketch of the history of medicine.

A memorial to Mrs. Harry A. Jacobs, Indianapolis, was conducted by Mrs. W. H. Hughes, Indianapolis.

Indiana's Auxiliary was honored this year by its state president, Mrs. Maurice VanCleave, being elected third vice-president of the national auxiliary.

State officers elected for the coming year were: president-elect, Mrs. Clarence L. Bock, Muncie; first vice-president, Mrs. Ernest O. Nay, Terre Haute; second vice-president, Mrs. George Dillinger, French Lick; third vice-president, Mrs. E. M. Van Buskirk, Fort Wayne; fourth vice-president, Mrs. Arthur J. Steffen, Wabash; recording secretary, Mrs. Harry Hellman, South Bend; corresponding secretary, Mrs. Byron K. Rusk, Indianapolis; treasurer, Mrs. C. V. Rozelle, Anderson.

1940. The ninety-first convention of the Indiana State Medical Association and the 13th annual meeting of the Woman's Auxiliary to this Association was held in French Lick, October 30, 1940, Mrs. William Tinney presiding.

Mrs. Maurice B. VanCleave, Terre Haute, conducted an impressive memorial for the following

deceased members of the auxiliary: Mrs. W. R. Davidson, Evansville; Mrs. Frank Timkhauser, Mrs. Fred Cheney, and Mrs. O. B. Norman, Indianapolis; Mrs. Orville E. Spurgeon and Mrs. Earle Green, Muncie; Mrs. Edward Wagoner, Burrows; Mrs. Russell LaBier and Mrs. F. L. Wedel, Terre Haute; Mrs. M. B. Strange, New Albany.

A musical tea, honoring state and county presidents was held at the French Lick Springs Hotel. The singers presented "Songs Befo' De Wah," in costume and it was a most pleasing entertainment.

Mrs. V. E. Holcomb of Charlestown, West Virginia, national president, brought greetings from the national auxiliary.

Fifteen new organizations for the year were reported by Mrs. Fred B. Wishard, Organization chairman. Mrs. Charles N. Combs, of Terre Haute, gave a splendid report from the national convention in New York City, 99 delegates present and 23,524 members in the national auxiliary. Thirty-seven states sent exhibits; Indiana was creditably represented. The auxiliaries were urged by Mrs. H. A. Ray, Fort Wayne, to cooperate with the medical association in the study of legislation; to assist in acquainting the public with laws that are unfavorable to medicine; to be able to answer medical questions intelligently and to go to the polls.

Mrs. O. G. Pfaff, Indianapolis, memorial chairman, gave the history of the pioneer patients and physicians.

Officers were elected as follows: president-elect, Mrs. Ernest O. Nay, Terre Haute; first vice-president, Mrs. George Dillinger, French Lick; second vice-president, Mrs. Arnold H. Duemling, Fort Wayne; third vice-president, Mrs. A. J. Steffen, Wabash; fourth vice-president, Mrs. H. A. Van Osdol, Evansville; recording secretary, Mrs. Charles Schneider, Evansville; corresponding secretary, Mrs. Thomas P. Owens, Muncie; treasurer, Mrs. Marion W. Hillman, South Bend.

Twenty-six auxiliaries were represented at this meeting, two of these being small societies organized as one, the Auxiliary of the North West Academy of Medicine.

1941. The fourteenth annual meeting of the Woman's Auxiliary to the Indiana State Medical Association met in Indianapolis, September 24, 1941; Mrs. C. L. Bock, Muncie, presided.

Following the pledge of allegiance to the flag, Mrs. E. M. Mendenhall, Fort Wayne, gave a beautiful memorial for the following members: Mrs. John R. Carney, Delphi; Mrs. W. W. Kraft, Oberland; Mrs. J. Don Miller, Indianapolis; Mrs. Earle Green and Mrs. W. A. Spurgeon, Muncie.

Mrs. Roscoe E. Mosiman, Seattle, Washington, national president, was present and extended greetings and good wishes. Mrs. Lester A. Smith, in behalf of the League of Women Voters, stressed the necessity of being well informed in order to be a good citizen and intelligent voter.

The historian, Mrs. U. G. Poland, urged the auxiliaries to have a complete list of the physicians in the war service, also to secure the biographies of pioneer doctors. Each county was asked to send to the state historian an edited history of physicians, dates of birth and death, and references to material about them, also to secure additional information for the county historian.

Officers were elected: president-elect, Mrs. Ernest O. Nay, Terre Haute; first vice-president, Mrs. George R. Dillinger, French Lick; second vice-president, Mrs. Arnold Duemling, Fort Wayne; third vice-president, Mrs. Arthur Steffen, Wabash; fourth vice-president, Mrs. H. A. Van Osdol, Indianapolis; recording secretary, Mrs. Charles Schneider, Evansville; corresponding secretary, Mrs. T. R. Owens, Muncie; treasurer, Mrs. Henry Hellman, South Bend; parliamentarian, Mrs. Charles F. Voyles, Indianapolis; councilor, Mrs. William E. Tinney, Indianapolis; and historian, Mrs. U. G. Poland, Muncie.

"Keep the control of medicine in the hands of the medical profession," was the message given by Mrs. E. O. Nay, Terre Haute, president-elect.

1942. A board meeting was held at the Columbia Club, March 19, 1942, Indianapolis, with Mrs. E. O. Nay presiding. Mrs. Fred B. Wishard, State Organizer, reported the loss of Adams and Morgan Counties and one new organization, Sullivan County, in February, 1942.

At this meeting it was decided to continue the gathering of material for the completion of the history of the pioneer physicians so long as it met with the approval of the Advisory Board. Mrs. Pfaff was granted \$125.00 to purchase a bronze plaque to replace the one in the Indiana University School of Medicine Building (this was reported at the Board meeting at French Lick, on September 30, 1942, as accomplished).

At the request of Mrs. Duemling, president-elect, she was given authority to appoint a chairman for the northern section and one for the southern section of the state.

Mrs. Frank Haggard, national president, of San Antonio and Mrs. E. O. Nay, Indiana state president, were honored with a tea.

In this year, we lost by death the following, who were memorialized: Mrs. Ralph J. Anderson, Mrs. Robert J. Masters, Mrs. Blanchard Pettijohn, Mrs. Loren Martin, Mrs. Raymond Ervin Mitchell, Mrs. William P. Garshwiler, all of Indianapolis, Mrs. Orville E. Spurgeon, and Mrs. Hugh A. Cowing, Muncie.

The following officers were elected: president-elect, Mrs. Arnold H. Duemling, Fort Wayne; first vice-president, Mrs. Frank C. Walker, Indianapolis; second vice-president, Mrs. John A. Gentile, New Albany; third vice-president, Mrs. F. M. Fargher, Michigan City; fourth vice-president, Mrs. W. C. Anderson, Terre Haute; recording secretary, Mrs. Wm. H. Wright, Fort Wayne; corre-

sponding secretary, Mrs. Don H. Mattox, Terre Haute; treasurer, Mrs. R. T. Hayes, Muncie; councilor, Mrs. C. L. Bock, Muncie; parliamentarian, Mrs. C. F. Voyles, Indianapolis; historian, Mrs. U. G. Poland, Muncie.

Dr. John Feree, secretary of the Indiana State Board of Health, spoke on "Civilian Participation in Our Health Program." He stressed the following points:

1. Health education; the importance of keeping well.
2. Support of the Public Health Ordinance, grade "A" milk, restaurant ordinance, etc.
3. Urge immunization as a health protection.
4. Assist in the civilian training for war.
5. Create a comfortable life with less comforts.
6. Get along with less—take care of what you have.
7. Make a search for salvage.
8. Buy bonds and stamps.
9. Help dispel rumors; spreading truth is a part of our job.

Mrs. Voyles installed the new officers. Mrs. Duemling, in her opening speech, urged that state officers be invited to visit local groups, to make each Auxiliary an intelligent and active organization.

Mrs. E. O. Nay has secured biographies of men in the medical profession: a portfolio of "History of Pioneer Physicians of Fort Wayne and Allen County Medical Auxiliary, Fort Wayne," "Early Pioneer Doctors of Porter County," "Pioneer Doctors of Vigo County," "Pioneer Doctors of Noble and LaGrange Counties (Northeastern Academy of Medicine)". Porter County sent a paper on the early pioneer doctors, prepared by Mrs. G. H. Stoner. Dr. J. B. Maple's "Medical History of Sullivan County, Indiana," also contains biographical sketches. Mrs. Kathryn Scott, president of the Sullivan County Auxiliary, made a complete outline of Dr. Maple's book, under the title, "Pioneer Doctors of Sullivan County." A biography of Dr. Goodwin Rogers, medical superintendent of the Northern Indiana Hospital for the insane at Longcliffe, Logansport, Indiana, was sent by his daughter.³ A biography of Dr. Graham N. Fitch, pioneer physician of Cass County is on file, also a biography of Madison J. Bray, M.D., pioneer physician of Vanderburgh County, compiled by the auxiliary of that county.

The Woman's Auxiliary of LaPorte County held a business meeting April 16, 1942 and the main topic was "Pioneer Doctors of LaPorte County." The record shows that the earliest physician to come to LaPorte was in 1833, when Thomas Vaughn cared for the people living in three cabins. The most outstanding physician during the period between 1833 and 1837 was Dr. Daniel Meeker, who located in LaPorte in 1835 and founded LaPorte University School of Medicine in 1842, later known as the Indiana Medical College.

A Board meeting was held at the Columbia Club, December 1, 1942. Mrs. Pfaff said a suggestion had been made by Dr. Wishard that the original plaque in honor of Indiana's medical heroes and heroines placed in Dr. Gatch's office be relocated in the Board of Health Building. This suggestion was approved.

1943. Mrs. H. A. Ray of Fort Wayne was appointed Organization chairman for Northern Indiana and Mrs. James Baxter, Jr., chairman for Southern Indiana, at the Board meeting May 5, 1943.

Officers elected were: president-elect, Mrs. James Baxter, Jr., New Albany; first vice-president, Mrs. Wm. H. Howard, Hammond; second vice-president, Mrs. Charles Viney, Logansport; third vice-president, Mrs. Frederick Gifford, Indianapolis; fourth vice-president, Mrs. M. A. Austin, Anderson; treasurer, Mrs. C. E. Munk, Kendallville; recording secretary, Mrs. Thomas R. Owen, Muncie; corresponding secretary, Mrs. E. M. Van Buskirk, Fort Wayne; councilor, Mrs. Ernest O. Nay, Terre Haute; parliamentarian, Mrs. Charles F. Voyles, Indianapolis; historian, Mrs. U. G. Poland, Muncie. Mrs. Voyles was named installing officer.

The state auxiliary was honored in having our state president, Mrs. Arnold Duemling, Fort Wayne, made third vice-president of the national auxiliary, 1944-1945.

The sixteenth annual meeting of the Woman's Auxiliary was held September 28, 1943, in Indianapolis, Mrs. Arnold H. Duemling, presiding.

A reception and tea was given at the Athletic Club in honor of Mrs. Eben J. Carey, national president from Wawatosa, Wisconsin, Mrs. Rollo H. Packard, past national president and Mrs. Schricker, wife of Governor Henry Schricker.

Lt. Commander Henry Hurd gave the address at the dinner in the evening on the subject of the work of the medical men in the service, and it was greatly enjoyed. Dr. C. H. McCaskey, president of the Indiana State Medical Association, was guest speaker at the annual breakfast, September 29, 1943.

A memorial to deceased members was given by Mrs. Maurice B. Van Cleave, Terre Haute: to Mrs. Carl Carney, Delphi, Mrs. Willard A. Price, Napanee, and the men and women who have given their lives in service in the present war.

Mrs. Eben J. Carey, national president, urged the members to keep in mind the national program: health education, post war planning, a meeting to be held each month; also to study the Wagner-Murray-Dingell bill, so that we may explain it to those whom we contact.

Auxiliaries have helped to establish agencies by giving Health Day programs, health plays and radio programs such as "Doctors at Work." The monthly *Bulletin* of the State Board of Health goes to many institutions.

1944. The May Board meeting was held May 3, 1944, at the Indianapolis Columbia Club. At this time we had a balance of \$730.60 in the treasury and a total membership of 770; 21 counties were organized.

Various counties reported they had made a study of the Wagner-Murray-Dingell bill in order to discuss it intelligently, before as many clubs as possible. A number of letters had been sent to Senators and Representatives asking them to vote against socialized medicine. Mrs. F. B. Wishard, chairman of Legislation, urged that we be alert to combat the influence of the organized forces for socialized medicine.

Mrs. W. I. Hughes, Public Relations Chairman, stated that there is a definite need for personal assurance.

Hancock and Clark Counties were organized this year.

The auxiliary members met in Murat Temple, Indianapolis, for the 18th annual meeting, October 2, 1944. Mrs. Baxter, state president, in her annual report stated that the unity of purpose of our organization had resulted in accomplishments beyond her expectations, and she gave five recommendations which are still good:

1. Answer correspondence promptly.
2. Each officer and chairman should present to her successor in writing a resume of her year's work, experiences good and bad, and offer suggestions for the following years.
3. That the state organization include in its budget expenses for the state convention.
4. That the four vice-presidents whose duties are to assist in the forming of new auxiliaries should come from four different geographical sections of the state.
5. Every auxiliary member should read the *Journal*.

The seventeenth annual meeting of the Woman's Auxiliary met in Indianapolis, October 3-4, 1943. A tea was held at the home of Governor and Mrs. Henry Schricker, honoring Mrs. D. W. Thomas, Locke Haven, Pa., national president of the Auxiliary to the American Medical Association. We were made to feel very welcome by Mrs. Schricker and spent an enjoyable hour.

Mrs. James W. Baxter, Jr., New Albany, presided at the breakfast and business meeting, October 4th. Mrs. D. W. Thomas, national president of the Auxiliary, addressed the delegates and stated that important problems before the people were child delinquency and physical fitness; these could be discussed through the public relations program to secure cooperation between the public and medical profession. The planning of a program had been started in July, under the direction of the American Medical Association and the National Council of Physical Fitness, a program to improve the opportunities of young men and women for gaining physical health.

At this time a recommendation was made that our calendar year be changed from October 1st to

* His son, the late Dr. Clark Rogers, practiced medicine in Indianapolis for many years.

May 1st; that our annual business meeting be held in April and be called "Meeting of the House of Delegates." Officers would be elected and installed at that time, reports of county presidents read, and delegates to the national convention appointed. The fiscal year would then correspond with the national fiscal year. Financial considerations made such a plan attractive, moreover the new state president would thereby have the opportunity of attending the national convention where she would get her instructions for her year's work, and all committee chairmen would have the summer to plan their work. The fall meeting would be held as usual and would be called the "General Assembly." With less business to take up time at the General Assembly, we could have more time for inspirational talks from the medical profession, national president and other outstanding speakers. The change, subsequently adopted, proved to be an excellent one.

Our state president, Mrs. Baxter, stressed the need of organization and reported that Clark and Hendricks Counties had organized. War Service had been emphasized in all auxiliaries and she said that we could help in planning the future of medicine after the war. At this time Mrs. O. G. Pfaff reported that she felt the work of the Pioneer Memorial Committee was completed, however, she hoped that we would keep a history of the physicians who had lost their lives in service in the recent war, for future reference.

Officers for 1944-1945 were: president-elect, Mrs. S. J. Petronella, East Chicago; vice-presidents, Mrs. C. E. Munk, Kendallville, Mrs. K. T. Knode, South Bend, Mrs. Wayne Elsten, Lapel, Mrs. R. G. Burman, Jeffersonville; recording secretary, Mrs. L. L. Blum, Terre Haute; corresponding secretary, Mrs. C. L. Bock, Indianapolis; treasurer, Mrs. A. W. Ratcliffe, Evansville.

Membership was at this time 775. An evening entertainment was held at the Murat Theatre in conjunction with the Indiana State Medical Association.

At the meeting of the Board of Directors in November, 1944, at Indianapolis, thirty members were present, including twelve county presidents. Mrs. Frank Gastineau, state president, gave an account of the annual conference of state presidents in Chicago, where prevention of juvenile delinquency was urged by use of the public relations program. At this time Mrs. Gastineau explained her plan for dividing the state to make for better organization and for contacting unorganized counties. It was accordingly later divided into four sections.

Mrs. Edgar Mendenhall, of Fort Wayne, moved that the House of Delegates meeting be a two-day session, with the Board meeting to be held the evening before the meeting of the House of Delegates; the motion was adopted.

1945. Mrs. Frank M. Gastineau, state president, called the first meeting of the House of Delegates at

the Columbia Club, April 26, 1945. The guests were welcomed by Mrs. Henry Leonard, Indianapolis; a response was made by Mrs. James Baxter, Jr.

Dr. J. E. Ferrell, president-elect of the Indiana State Medical Association, gave an inspiring talk in which he congratulated the auxiliary members for being stabilizers for the medical profession, and for their fight against socialized medicine. He discussed the new insurance program.

Dr. Norman Beatty, chairman of the Committee on Public Policy and Legislation, and Mr. Thomas Hendricks, executive secretary of the Indiana State Medical Association, also spoke.

In her report, Mrs. Gastineau stated that she had visited five county organizations. Indiana was on the honor roll for *Hygeia* subscriptions, with an increase of 265% in two years, due to the earnest work of Mrs. O. H. Bakemeier, as *Hygeia* chairman.

There was no election of officers in 1945; same officers served until 1946.

The evening before the meeting of the House of Delegates Mrs. Gastineau entertained the Board of Directors at a buffet supper in her home. Thirty guests were present, and a business meeting was conducted.

1946. At the House of Delegates meeting in Indianapolis, April 25, 1946, Dr. Walter U. Kennedy, New Castle, gave an address on the subject of socialized medicine. He discussed the failure of the system in Europe, the dangers to America if a similar plan should be adopted here, and the value of insurance controlled and operated by doctors.

Members elected as new officers were: president-elect, Mrs. A. W. Ratcliffe, Evansville; vice-presidents, Mrs. C. E. Munk, Kendallville, Mrs. C. L. Wise, Camden, Mrs. Arthur Richter, Indianapolis, Mrs. Morton Wolfe, New Albany; treasurer, Mrs. Wendell Kelly, Anderson; recording secretary, Mrs. M. E. Allen, Greenfield; corresponding secretary, Mrs. David A. Eisenberg, Hammond.

The Board of Directors met October 29, 1946 in Murat Temple, Indianapolis. A special effort was made this year to increase the membership at large. The *Journal of the Indiana State Medical Association* gives space for reports each month so that each doctor's wife has an opportunity to be informed on the work of the auxiliary. It was decided to discontinue the physical fitness program.

An explanatory talk was given at this meeting by Mr. Rollis K. Weesner, executive secretary of the Lake County Medical Society, who spoke on socialized medicine and the Wagner-Murray-Dingell bill. He brought out in his talk its relation to the medical profession and its harmful effect on physicians. Auxiliary members were urged to present this discussion before their different clubs since a poll showed that the general public was little informed regarding socialized medicine.

It was the opinion of another speaker, Dr. N. K. Forster, Hammond, that the next ten years will bring much change in the practice of medicine. There will be more hospitals with better facilities. This is the American way of living, to go as far as one may choose by studying in a free country. It is our privilege and duty to protect and preserve this right to freedom.

1947. April 22, 1947, the members of the House of Delegates were entertained at a tea in the home of Mrs. Emmett B. Lamb, president of the Indianapolis Auxiliary, honoring Mrs. Jesse D. Hamer of Tuscon, Arizona, national president.

A dinner followed at the Athletic Club, in honor of Mrs. Hamer, and in her address she spoke of things of interest to the Auxiliary:

1. Seeing that all clubs are enlightened by prepared speakers on subjects that will benefit the medical profession, also through *Hygeia* and radio.

2. Providing records and portable players in schools to interest children in public health measures, to eliminate such menaces as open dinner buckets and public drinking cups, and spread health education.

3. A shortage of nurses has caused a shortage of 33,000 beds in hospitals; 14,000 student nurses are needed now.

At this time, Ray Smith, executive secretary of the Indiana State Medical Association, informed us on what had been done in the State Legislature, relating to the field of public health.

Officers elected were: president-elect, Mrs. William Morrison, Kokomo; vice-presidents, Mrs. Charles Viney, Logansport, Mrs. M. J. Thornton, South Bend, Mrs. Leon Blum, Terre Haute, Mrs. James W. Baxter, Jr., New Albany; recording secretary, Mrs. Truman Caylor, Bluffton; corresponding secretary, Mrs. J. W. MacDonald, Evansville; treasurer, Mrs. Wendell Kelly, Anderson.

Mrs. A. W. Ratcliffe, Evansville, presided at the directors meeting at French Lick, October 28, 1947. Thirty delegates answered roll call and Mrs. Wendell Kelly, state treasurer, reported 1,417 paid members.

Whitley County was reported as organized.

Mrs. Ratcliffe gave a detailed account of her problems as editor of *The Hoosier Doctor's Wife*. Through the generosity of the Indiana State Medical Association, who gave \$500.00 to help defray the expense of this publication, we have all enjoyed this paper. It is a means of bringing our members closer together and keeping the unorganized counties informed on the work that is being done by the auxiliaries. Beginning with a two-page mimeographed sheet, July, 1947, it has grown to a four-page printed periodical.

Mrs. Ratcliffe's slogan has been, "Every doctor's wife an auxiliary member."

At this meeting a school of instructions was held for the auxiliary members, with round table discussions on legislation, public relations, administration, organization and publication.

For several years a number of auxiliaries have subscribed for extra copies of *Hygeia* to be placed in schools and libraries, to spread knowledge of new health methods. One of the projects this year has been the promoting of health education by radio. This has grown into a worthwhile program.

A complete roster, with addresses of the membership of the auxiliary, was published in the January issue of the *Journal of the Indiana State Medical Association*. Mrs. Baxter brought up the question of what can be done to keep the interest of the older members. No solution was given, but it is hoped that their thoughts are still with us. A display of the photographs of many of the physicians in childhood was enjoyed by all present. This exhibit was under the guidance of Mrs. C. C. Taylor, Indianapolis.

1948. On April 27-28, 1948, the House of Delegates met in Evansville. Mrs. W. R. Morrison, of Kokomo, presided. Officers elected and installed were: Mrs. Truman Caylor, Bluffton, president-elect; Mrs. Lawrence Shinaberry, Fort Wayne, Mrs. George Wagoner, Delphi, Mrs. Porter J. Coultas, Tell City, and Mrs. James W. Baxter, Jr., New Albany, vice-presidents; Mrs. Wendell C. Kelly, Anderson, treasurer; Mrs. Henry W. Bopp, Terre Haute, recording secretary; Mrs. Charles Viney, Logansport, corresponding secretary.

Miami and Morgan Counties were organized this year, also Clinton County, which later withdrew. Indiana received national recognition for having at least one member in each county. The study outline for legislation, published in the October, 1947, issue of *The Hoosier Doctor's Wife*, was also commended at the national convention.

Accomplishments of the year included nursing recruitment, radio programs using American Medical Association transcriptions and one television program by Gary children.

In September, 1948, the Woman's Auxiliary to the Indiana State Medical Association completed twenty-one years of active work in educational, philanthropic and social work, not only for the state of Indiana but for the medical profession.

A list of the presidents who have guided it through the years, follows:

1. Mrs. Frank W. Cregor, Indianapolis.....1928
2. Mrs. W. R. Davidson, Evansville.....1929
3. Mrs. M. A. Austin, Anderson.....1930
4. Mrs. William S. Tomlin, Indianapolis....1931
5. Mrs. L. E. Fritsch, Evansville.....1932
6. Mrs. Charles F. Voyles, Indianapolis....1933
7. Mrs. I. N. Trent, Muncie.....1934
8. Mrs. Edmund D. Clark, Indianapolis....1935
9. Mrs. Randolph L. Compton, Osgood.....1936
10. Mrs. Marcus Ravdin, Evansville.....1937
11. Mrs. Fred B. Wishard, Anderson.....1938
12. Mrs. Maurice B. VanCleave, Terre Haute.1939
13. Mrs. Wm. E. Tinney, Indianapolis.....1940
14. Mrs. Clarence L. Bock, Muncie.....1941
15. Mrs. Ernest O. Nay, Terre Haute.....1942
16. Mrs. Arnold H. Duemling, Fort Wayne...1943

17. Mrs. James W. Baxter, Jr., New Albany . . . 1944
18. Mrs. Frank M. Gastineau, Indianapolis . . . 1945
19. Mrs. S. J. Petronella, East Chicago 1946
20. Mrs. A. W. Ratcliffe, Evansville 1947
21. Mrs. W. R. Morrison, Kokomo 1948

From the beginning of the auxiliary with one unit, in Indianapolis, there are now forty counties organized with a membership of 1,715.

Adams-Allen	Marshall
Bartholomew-Brown	Miami
Carroll	Montgomery
Cass	Morgan
Clark	Northeastern Academy
Clinton (later with- drawn)	(DeKalb)
	(Noble)
Delaware-Blackford	(Lagrange)
Elkhart	(Steuben)
Floyd	Perry
Fulton	Porter
Gibson	St. Joseph
Hancock	Sullivan
Howard	Tippecanoe
Johnson	Vanderburgh
Lake	Vigo
LaPorte	Wayne-Union
Madison	Wills
Marion	Whitley

The auxiliary has grown steadily through the years, under the leadership of progressive women and has been a lasting influence for good in every county organized. The programs arranged have stimulated interest and have helped to form public opinion in health education. Each year finds new interests for the auxiliary in Indiana and each president sees the membership and interest increase.

May the coming years bring greater advancement of health education in Indiana, a greater fellowship among physicians and wives and a continued program of progress in every auxiliary chapter in the state under the approval of the Indiana State Medical Association.

Dr. Floyd T. Romberger, in his presidential address before the Indiana State Medical Association, said in October, 1947: "Over the years the ladies have labored with many odds and some handicaps against them. These obstacles are not unsurmountable. Our Auxiliary is part and parcel of our organized medical profession, its members are married to us, we should work together in a truly beneficent family relationship, they accepting us, we them." Let's not tear up the lottery ticket. It could be a winner!"

XI

A HUNDRED YEARS OF PSYCHIATRY IN INDIANA

MAX A. BAHR, M.D.*

THE evolution of psychiatry from the period of exorcism, charms, the practices of various cults, tortures in prison and even sentences of death, to the present status of its scientific application is one of the most fascinating and interesting chapters in the history of medicine.

Records of abnormal mental phenomena reach back to the very dawn of history and even before there were written records there must have been forms of mental disease. In the Old Testament we read of Saul's recurring periods of depression, when "the evil spirit from the Lord" was upon him and we read of the delirium of Nebuchadnezzar, in which he believed himself changed into an animal. In the work of Homer we are told that Ulysses simulated madness to justify his abstention from the Trojan War.

Accompanying the abnormal phenomena through the various ages of history there has always been an attempted explanation, because the demand for explanation is a fundamental character of the human mind.

Thus there has been the "demonological conception" where the phenomena of insanity were regarded as the manifestations of some spiritual being, God or demon, who either actually inhabited

the body of his victim, or merely played upon him from without.

With the coming of Hippocrates, however, somewhere about the year 460 B.C., the conception of insanity in Greece underwent a radical change. Hippocrates laid down the principle that the brain was the organ of the mind, and that insanity was merely the result of some disturbance in this organ. He "led his patients out of the temple of Aesculapius and proceeded to treat them along the lines of ordinary medicine."

Later mental phenomena were grouped together under the conception of "witchcraft" one of the most characteristic products of medieval thought. The determination of the existence of the "devil's claw" which we now recognize as patches of "hysterical anaesthesia," constituted the procedure of the witch trial. This atrocious institution obtained a firm hold on the nations of Europe and persisted even into the eighteenth century. Many thousands of people were executed each year for witchcraft.

At a still later period there was the "political conception." Although the insane were no longer regarded as the peculiar property of the devil, it was thought that they had no claim upon the consideration of society. So long as the madman was prevented from troubling his fellowmen the community felt that every duty had been dis-

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charged. This was the epoch of dungeons and chains.

By the end of the eighteenth century the view had attained a firm hold that abnormal mental phenomena must be attacked along the lines which everywhere else led to a material advance in knowledge. At that period the foundations were laid for a genuine scientific study of insanity.

Psychiatry has undergone a great development during the past hundred years and a considerable amount of knowledge has now been accumulated. At the beginning of the nineteenth century, the physiological conception had attained almost universal conception. Research began to be devoted to the anatomy and physiology of the brain and then the psychological conception was applied on the view that mental processes can be directly studied without any reference to the accompanying changes which are presumed to take place in the brain. The psychological era followed and insanity was then, therefore, properly attacked from the viewpoint of psychology.

At the beginning of the century there had come into being in Indiana the development of the humanitarian period in the case of the mentally ill. This of course, is roughly dated from Pinel's release of the "insane" at Salpetriere in 1793, but the significance of this act of Pinel took a long time to gain recognition, and in many instances a long time to even be heard of. But the attitude towards the mentally ill which this act of Pinel symbolizes did finally become a moving principle in Indiana as early as 1827 in that the acceptance of the case of the "insane" as a problem properly belonging to the state fitted in with the humanitarian movement which was directed to removing the "insane" from the almshouses and the jails where so many of them were kept confined in the most deplorable state of neglect and misery.

The transition of this archaic and cruel stage of the treatment of the mentally ill, to its present scientific approach of psychiatry was a very slow one.

In 1827, Square 22, Indianapolis, was set aside for a state hospital and "lunatic asylum." The institution was not built at that time but a log cabin on that square was used as a "crazy house." This step was motivated by Dorothea Dix in 1844 before the General Assembly of that year in consequence of visits of inspection of the insane in almshouses and jails, within a few miles of the Capitol. The law makers, roused, created a State Lunatic Asylum, the name of which was changed in 1846 to the Indiana Hospital for the Insane and later still to the Central State Hospital. This change of name, which indicated a more rational and scientific conception of what institutions of the insane should be, was followed in many states, notably in New York, where some forty years later the name "asylum" was changed to "state hospital."

The first real attempt towards institutional care of the insane in Indiana was a memorial to the

Legislature of 1832. A favorable report was made, but nothing further was done until 1844 when Governor Bigger presented the matter in his message and Dr. U. S. Connett of the Senate moved an amendment to the revenue bill, that one cent on the hundred dollars be levied as a fund with which to erect a "lunatic asylum," which was adopted. This levy produced \$12,000 during the year and was continued.

During the session of the Legislature of 1844-45 an "Act to provide for the procuring a suitable site for the erection of a State Lunatic Asylum" was passed and approved January 13, 1845.

Section 1 of said Act reads as follows: "Be it enacted by the General Assembly of the State of Indiana, that John Evans, Livingston Dunlap and James Blake be, and they are hereby appointed a Board of Commissioners to select and purchase such a tract of land, not exceeding two hundred acres in quantity, as may be most suitable in regard to health and convenience for the location of a State Lunatic Asylum."

Under section 3 and 4 of the same Act the commissioners were instructed "to obtain all the information possible, by correspondence and otherwise, concerning the best plans and specifications and methods of managing an asylum for lunatics," and submit the result of their investigations to the Legislature of 1846.

The first meeting of the commissioners was held in the city of Indianapolis at the office of Doctor Dunlap, February 1, 1845. At this time Doctor Evans was appointed an agent of the Board "to gather such information as he may think necessary to lay before the Board, on the subject of the location, plans and buildings and modes of managing hospital for the insane."

On May 30, 1845 the commissioners again met at the office of Doctor Dunlap. Doctor Evans submitted a report on his trip to numerous institutions. This report contains the following paragraph:

"Again it is important that an institution which depends upon the benevolence and liberality of the Legislature for its erection and must continue to do so year after year for its support, should be so situated that these legislators may see the blessed fruits of their philanthropy; and again, it should be so situated that they can exercise a guardian care over it; to guard against, detect and correct abuses, if any arise. Nor is this all; it is most necessary that they should be able to inspect and thoroughly understand its wants, that knowing, they should supply them." He also reports that "the wants of our state will probably demand at present an institution for from one hundred to one hundred and fifty patients."

At this meeting it was agreed that general survey of the county adjacent to the city of Indianapolis be made by the Board of Commissioners for the purpose of selecting the most advantageous site in its vicinity. On August 28, 1845 the com-

missioners had another meeting and "it was decided that the farm belonging to N. Bolton, lying two miles west of Indianapolis on the Macadamized National Road, possessed more advantages for a site for a hospital for the insane than any other that could be obtained; and it was unanimously agreed that the same be purchased at the rate of thirty-three dollars and twelve and one-half cent per acre."

The property (one hundred and sixty acres) passed to the State of Indiana on August 29, 1845.

On December 22, 1845 the Board of Commissioners drew up a full report for the Legislature of their plans and recommendations. On January 21, 1846 they met for the purpose of considering the new law passed by the Legislature entitled, "An Act to provide for the erection of suitable buildings for the use of the Indiana Hospital for the Insane," which Act was approved January 19, 1846. Consequently the first institution in Indiana for the reception of mental cases was born and the first eight cases were admitted on the opening day at the Central State Hospital, November 21, 1848. This building was replaced by the first of a series of modern cottages in 1931. In 1938 the hospital acquired the county infirmary approximately two miles from the parent institution. This section of land contains 200 acres and considerable improvements and replacement of building had to be made before it could be satisfactorily utilized for hospital purposes.

In 1865 a law was enacted which required the commissioners of the insane to take charge of and provide for the incurables in the same manner as the curables. The insane were entitled to admission on a county quota, pro rata of population, but there was not room to take care of them all.

In 1879 a large, new department for women was equipped and for a time eased the pressure of admission. But the numbers increased more rapidly than the provision for them, and despite the law of 1865, many of the incurables were returned to the counties to make room for new and supposedly curable cases. This plan manifestly led to much suffering and abuse. The county asylums are ill adapted for insane people.

In 1883 there occurred one of those not infrequent sessions of the Indiana General Assembly where the spirit of reform seems to have taken possession of the members. At that time a law was enacted creating three so-called additional hospitals for the insane, one each in the northern, eastern and southern parts of the state. A special board of construction was appointed and a medical engineer, or superintendent of construction was chosen in the person of Dr. Joseph G. Rogers, a highly skilled physician and a man with a genius for executive and constructive work.

Under this Board sites were secured near Logansport, Richmond and Evansville and very comprehensive plans adopted. The old and standardized plans of hospital building were considered

obsolete. At Logansport the plan of two-story detached blocks, at Richmond a very complete cottage plan, and at Evansville the radiate plan were decided on. The Evansville Hospital was completely destroyed by a disastrous fire in 1943, and has been rebuilt since that time.

In 1883 the state adopted a radical change of policy as regards incurables. No patients were to be discharged from the new hospital, either to their own care as cured, or to that county from whence they came "until their physical and mental condition justifies it." This gave rise to the popular misconception that the new institutions were for incurables, and they were often spoken of as asylums for the chronic insane.

The new law applied only to the districts allotted to the new hospital, so that for some years there existed the anomalous condition of one law applying to 49 counties of the state and another to the remaining 43. This was corrected some years later and the state accurately redistricted for the insane.

The appropriations made in 1883 were merely the beginning of what was needed, and sessions of the next few years were governed by conditions of economic stringency which prevented the prompt completion of the comprehensive plan. However, in 1888 the Northern Hospital was equipped and at once filled to overflowing with patients, not only from its own district but from other parts of the state. The Eastern Hospital was opened in August, 1890, and the Southern in October, 1890.

Even with four state hospitals of large capacity the needs of the insane were not met. The population of the state was growing and it seemed that the number of insane was increasing even more rapidly. The crowding of the hospitals, with the consequent refusal to accept patients, was so serious that Marion County in 1900 erected a county asylum for incurable insane with room for 200 patients. This institution was eventually taken over in 1939 by the Central State Hospital at the time of the acquisition by the state of the county infirmary. In other counties, the chronic insane were still found in the poor asylums.

In 1905 the state established a fifth hospital for the Southeastern district, which was opened August 1, 1910. This is beautifully situated on a bluff overlooking the city of Madison, and commanding views for many miles up and down the Ohio river. An account of the admirable method which was adopted for choosing the location of this hospital, was published in *The Survey* for December 2, 1905. Its procedure established a precedent which might well be followed everywhere and has already been followed in locating other institutions in Indiana. At the present time a sixth hospital is in the process of construction at Westville, LaPorte County, by an appropriation granted by the Legislature of 1947.

About those confined within the enclosures of these early state hospitals which were generally decorated with steeples of mysterious significance,

steeple which have even been interpreted as torture chambers, there existed many misconceptions.

There dwelt in these institutions for many decades a strange and unusual group of medical men known as psychiatrists, caretakers of the insane. They were physicians, scientists, medical men, but individuals with so extraordinary and incredible an interest that they were incomprehensible to the general physician outside the institutions. However, with the passage of time and with the assistance of pathologists, these physicians accumulated an experience with the behavior of insane individuals which gave them an understanding of why these people acted queer, opening up an entire new field in the science of the human mind. They discovered that there were general laws governing behavior, laws as definite as those governing breathing and digestion. They learned, too, the ways in which a knowledge of these laws might be used to rehabilitate some of the mental wrecks. With an understanding of these observations psychiatry came into its own and finally became recognized as a medical specialty.

Thus psychiatry became acknowledged by the medical profession as a topic of systematic investigation and teaching on an equal footing with the diseases with which general medicine dealt. The early attacks, as previously mentioned, were carried out under the domination of the pathological anatomists. The nineteenth century closed with a creditable record of advance in our knowledge of the structure of the brain and of the detailed changes in the parenchyma and supporting structures in a variety of morbid conditions. Psychiatrists were convinced at that time that the secret of mental disease would be found in the brain. Here interminable sections of the brain were made and stained, hoping against hope that the secret would be discovered and that the physical basis of the patient's symptoms would disclose itself in a visible pathology of the brain structure, particularly cortical structure.

Those who were engaged in it never thought of questioning their basic premises and were sure that if they failed to find what they were looking for it was only because their methods were not sufficiently refined. At any rate this method of investigation dominated the field for many years and the psychiatrists of the state hospital at the beginning of the present century felt that they were living up to what was expected of them if they incorporated a laboratory along with a dead house, in which the tissues of the patients autopsied could be examined microscopically, particularly the nervous tissues. A dead house pathology was the opening wedge for the entrance of science into the study of mental disease, as it had for a long time been the study in general medicine.

Passing through this era of structural pathology there followed the descriptive era, during which the clinical pictures of psychotic entities were drawn with painstaking exactitude. Very early, however,

in the scientific investigations of the somatic exploration there followed the brilliant solution of the problem of paresis; the neuropathologic conquest of the senile and arteriosclerotic psychoses, the identification in the clinical laboratory of the formulas of many psychiatric reactions elicited by exogenous intoxications and endogenous toxicities.

Relatively soon psychiatrists became dissatisfied with mere clinical descriptions, however carefully made and reported. There was increasing evidence that much important material was hidden below the surface; that in every human being there were deep psychic reservoirs, the content of which was not within the area of every day consciousness, and there arose the psychogenic interpretation of psychiatry. Thus a new movement of fundamental importance had been initiated, which was to have profound influence on psychiatric thought.

At the beginning of the present century the full implication of the new formulations of the personality was far from being realized. Explanations of disturbed behavior and outlook were industriously sought through the detailed study of the impersonal factors, and the fruits of histopathological study were much in the foreground. Nissel had finally arrived at a precise formulation of the histopathological picture in general paresis; the changes in other forms of cerebral lues, in cerebral vascular disease, in senile degeneration, were differentiated from each other. New technical methods were being elaborated and it was hoped that these methods might reveal structural changes not previously demonstrated, to throw light on the more baffling mental disorders. The optimistic hopes of some for quick returns were, however, not to be realized and the clinician still awaited from the histopathologist an authoritative interpretation of his contribution to some of the vexing problems in psychiatry.

While pathological anatomy was of value in demonstrating the structural changes underlying certain disorders and supplying criteria for the establishment of homogenous groups of cases, it left the fundamental problems of even these disorders to be investigated by other methods. It could demonstrate the characteristic histopathological changes in general paralysis and did finally track the spirochaeta to its lair, but the further analysis of the disease was a matter for the clinician with the assistance of the physiologist, the biochemist and the protozoologist.

There later became evident that which brought a powerful reenforcement to the view that the individual psychosis must be considered not as merely symptomatic of an impersonal disease process but as a part of the adaptation of a human individual to the special demands of his inner nature and the environmental situation. The study of the psychoses as a problem in human adaptation was the study of the individual personality with its own life situation, and the personality came to occupy the center of the psychiatric stage.

As in the production of an infectious disease the specific organism may be made responsible, or, on

the other hand, the lack of immunity of the patient, so in mental disorder we may emphasize the external factors which break down the resistance of the patient or the inadequate immunity of the patient. The estimate of the immunity of the personality was the task of the psychiatrist, and in estimating this psychoimmunity the psychiatrist had to weigh the significance of the family, the moulding influences of early situations, the sensitizing or immunizing result of special experiences, the subtle internal evolution and adjustment of the component forces of the personality, the intimate interplay between the personality of the patient and the other personalities with which he was in close contact. The so-called psychosis, the problem of the psychiatrist, was this system of forces at a particular phase of its evolution studied in the setting of a particular situation. The interest of the psychiatrist to a large extent was supplemented by interest in the dynamic problem of the individual case and in considering anew the possibility of treatment and prevention. The dominating trend in psychiatry became the emphasis on the personality, and on the conception of the psychosis as the revelation of the personality struggling with its special task. The problem of the psychiatrist was no longer to identify a clinical picture but to contact with the actual dynamic situation, to reconstruct in detail the life history, with attention to the sensitizing or conditioning influence of environmental factors, and with due appreciation of the nature of emotional disturbances, of substitutive and evasive reactions, of symbolic expressions, of the various modes of getting satisfaction for the complicated needs of the individual.

Psychiatry then soon after escaped from the narrow field of mental disorders into the broader field of human activities; it made excursion into the home, the school, the factory, the legislative assembly and into the wards of the general hospital. This has not only led to useful contributions to these fields but has also enriched the data of psychopathology. It broadened the insight of the psychiatrist into the way in which man deals with his problems and into the diversity of human endowment and adaptation and total career. It emphasized the solidarity of the individual with the group, the bearing of the social background on the disordered mentality of the individual patient. It demonstrated that the methods and principles of psychiatry have validity in the study of human behavior in many settings where the question of disease is quite irrelevant. Thus psychiatry returned to its original material, freed from the incubus of the disease concept, willing to study the psychosis as an individual problem in human behavior.

The trends of investigation and interpretation of modern psychiatry especially in past two decades has respectively emphasized impersonal factors, as various physiological mechanisms and external causative agents; personal factors, as the structure of the personality with its special lines of sensi-

tiveness; the environmental factors, as the family, social atmosphere, and general culture. In each of these fields increase of knowledge has raised important questions with regard to treatment and prevention. In each of these fields important gains have been made and a program of amelioration outlined. One can refer to such obvious gains as the improvement in the treatment of general paralysis with malaria, a diagnosis which at the beginning of the century meant a sentence of death within two to five years, while now one expects one-third of the patients admitted with this diagnosis to be restored to occupational efficiency and another third to maintain a modest degree of social adaptation for a prolonged period. In regard to the second field, where difficulties within the personality are important, one may refer to the much more precise and far reaching treatment of the psychoneuroses and of many cases of distortion and inhibited personality. As to the environmental factors, one may point to cases where the appreciation of this factor with resultant modification of the atmosphere in the home, the schoolroom, or the factory, or with transfers to a different environment, has brought about quite dramatic changes.

Psychiatry has also developed its own group of specialties, as mental hygiene, child guidance, industrial psychiatry, medico-legal psychiatry, penal psychiatry. Each of these disciplines performs a large and much needed function. Especially in the last decade has it been emphasized that the territory of internal medicine and its specialties and the territory of psychiatry merge into each other.

In this connection, the rapidly increasing, so-called psychosomatic medicine is significant. Psychosomatic medicine has staked on a large clinical area, adjoining on one side the territory of internal medicine and subdivisions, and, on the other the territory of psychiatry. In this area psychiatrists work on the same problems as do their fellow physicians. It is the meeting place of the somatic and the functional and here, as in certain instances of peptic ulcer, may be witnessed the end-products, in terms of tissue pathology, of too long continued functional derangements conditioned by anxiety.

Once having been divested of its cruel and archaic method of treating patients and committed to a humanitarian policy of scientific understanding and treatment of its patients, psychiatry in not more than a century has made remarkable progress.

It has been learned to avoid giving the impression that treatment is exclusively limited in the individual case to one or another of three main fields of endeavor. In the individual case it may be necessary to treat the physical health, the metabolism, the focal infection as well as to deal with the internal equilibrium of the patient, and to see whether the patient can be relieved of undue environmental strains, or receive some more support from the sociological group. It has also been revealed in recent times that psychiatry deals with

the individual as a whole, and should receive help at whatever level it may be available. The enthusiast may concentrate exclusively on one avenue of approach and one line of treatment, but the trend of psychiatric thought is to emphasize the integration of all the component forces which are only abstract aspects of the unitary organism. As the functions of that organism may be disturbed at various levels and from various directions, so in the restoration or melioration of function, psychiatry has come to recognize that it must be willing to utilize all the resources that are at its disposal.

During my fifty years of service at the Central State Hospital I have witnessed many changes there, also in our other state institutions, as the replacement and remodeling of old buildings, the addition of facilities for medical care, the equipment of operating rooms, the construction of amusement halls, the development of pathological laboratories which affords the opportunity for carrying on extended research work, the introduction of occupational therapy departments and many other additions. All of these added to the ability of the institution to care properly for its sick patients, and to the interest and variety of the institutional environment which made for the contentment of the patients, what is at times almost equally important for the relatives also.

Upon my entering the field of psychiatry, the old ideas of mental illness, which had dominated so long, were still in existence here as they were elsewhere throughout the country. Patients were either maniacal or melancholic or demented. Paresis was occasionally diagnosed but there was no more than a suspicion that there was any connection between it and syphilis. Mental examinations consisted of undirected conversations with the patient followed by brief notes written in ponderous case books by long hand. There was very little if any suggestion that the mental symptoms had any meaning back of them, that the psychosis was a reaction of the organism in any way defensive, compensatory or otherwise. The whole situation was looked upon as being pretty much of a mystery, and there was hardly any light to be had on these questions from any source. Finally an evolution and development in this branch of medicine manifested itself when its intricate problems were attacked from the viewpoint of science.

Psychiatry finally emerged out of its shell and is now extending and exerting itself into extraneural activities.

It had been my contention for many years that a diagnostic center as being proposed for a screening hospital and now under construction at Indiana University Medical School would be a great step in the advancement of psychiatry.

Such a psychiatric center is a progressive step in Indiana and will serve a threefold purpose:

1. Proper and temporary care prior to commitment to the general wards of a state institution.

2. Treatment of a number of patients who can be treated with benefit and advantage, and who by early and intensive treatment, during the incipient period of their illness, can thus avoid the commitment to the general wards of a state institution.

3. The investigation of the clinical material for the teaching of psychiatry.

Such an institution can also render a splendid community service in its mental health program, to wit, through:

1. Information to the lay public, medical profession, school, club, etc.

2. Field stations in the community in which the mental clinics will serve the furloughed cases, public schools, the courts, physicians, social service workers, etc.

3. Procuring the cooperation of the medical profession and general hospital in the treatment of the borderland cases.

4. A survey of important elements in the management or mismanagement of mental hygiene problems.

5. Organization of the enlightened for the extension of their sphere of influence.

6. The establishment of local clinics for the purpose of rendering first aid in mental hygiene problems as they occur and for the purpose of continuing the demonstration of the need of real constructive work in this field of public health in order to diminish the incidence of these problems in the future.

7. Aid in securing such appropriations and statutory provisions as are possible for state administration of care directed to the recovery of mentally afflicted patients, to the prevention of nervous and mental diseases, and to the diminution of the birth rate of the mentally defective.

The Central State Hospital has been practicing mental hygiene for many years in that since it has been one of the pioneers in the malaria therapy of paresis in America; it has since 1930 sent over 2,000 samples of malaria blood for inoculation of parietic patients to physicians throughout our state and adjoining states. Consequently such cases were not committed to our state institution where they would have remained from one to four years if they would not have had such therapy.

The medicine of the past has developed preponderantly along physical lines and in the direction of specialization, so that highly trained men have been functioning only too often as technicians interested in diseases and organs rather than sick individuals. Psychiatry in its recent developments has been the only medical specialty that because of its nature was called upon to deal with the whole individual in any real sense. Psychiatry was forced more nearly to acting upon this principle than any other specialty; and now it has come about as a result of psychiatric investigations, psychiatric thought and the psychiatric point of view, that the individual is recognized as vastly more

important than any of his diseases or his organs. In fact the concept that considers the organism as a whole, and the necessary correlate thereto, that there is a psychological factor in every illness, bids fair to cause a revolution in medical thinking that will be of great significance in future medicine.

Psychiatry strikes at the very heart of the most important and significant problem that is presented to man, namely the problem of himself, so its

development in the future will be of utmost significance. Indiana will not be found lacking in attempting to reach its ultimate goal in this regard.

Public interest and understanding is required for complete success in our state hospital program. A continuous public endorsement and financial support will ultimately assure the completion and effective operation of mental health facilities in Indiana.

XII

HISTORY OF NURSING IN INDIANA

DOTALINE E. ALLEN, R.N.*

NURSING SERVICE IN INDIANA

Hospital Nursing

ONE HUNDRED years ago in Indiana, nursing as a profession was unknown. The sick were cared for in their homes by members of the family with the kindly assistance of neighbors and friends. Epidemics of cholera, dysentery, and diphtheria were frequent and severe.¹ The care and treatment given the sick was greatly influenced by the superstitions, fears, and traditions of the period. The germ theory, immunization, and hospitals were still in the future.

An attempt to establish a hospital in Indianapolis in 1858 was unsuccessful. Although a small building was completed, no requests for admission were received and therefore no plans were made to care for the sick.² The situation changed during the Civil War, when an emergency request to care for Indiana soldiers was received and many women volunteered to assist in caring for the sick and injured.³ Governor Morton arranged to have the wounded cared for in buildings or homes in three centers in Indiana—Evansville, Indianapolis, and New Albany. Some of the Sisters of Providence who were teaching in grammar schools and academies in Indiana left the schools to serve as nurses in the Military Hospital at Indianapolis.⁴ However, immediately after the Civil War there again was little interest shown in maintaining a hospital in Indianapolis, and it was not until 1866 that the City Hospital was finally opened.⁵

Other hospitals followed, and in 1905 the Indiana State Legislature passed the Carmichael law, which enabled a County Council to appropriate money to build a hospital provided an association was formed which would purchase the ground and furnish and equip the hospital. The Good Samaritan Hospital of Vincennes was the first county hospital to be established in the state of Indiana. It was opened in 1908 and had a bed capacity of 25 patients.⁶

With the establishment of hospitals, the need for persons to care for the sick and operate the institutions naturally followed. The first school of nursing was established in Indiana in 1883.⁷ Before that time, and even later when the supply was still inadequate, it was necessary to obtain nurses or nurse workers from other sources. Several methods were used to meet the need. Some hospitals used workers with previous experience in the care of the sick, sometimes giving them special instruction after they were employed by the hospitals. Since professional schools of nursing were established in the East by 1873, some of the Indiana hospitals were able to obtain nurses prepared in these schools, and others imported nurses from abroad.

Indianapolis City Hospital, with a bed capacity of 50, used a man to care for the male patients and a woman to care for the female patients. St. Elizabeth Hospital in Lafayette, with a bed capacity of 19, was founded in 1876 by six sisters of the Poor Sisters of St. Francis Seraph of Perpetual Adoration, from Germany. The nursing care was given only by the sisters. St. Vincent's Hospital, Indianapolis, with a bed capacity of 25, was opened for the care of patients in 1881, and professional nurses from the East were used to give nursing care. St. Joseph Hospital, South Bend, with an average of five patients, when founded in 1882, used sisters to care for the sick. St. Anthony's Hospital, Terre Haute, with a bed capacity of 18, founded in 1882, and St. Margaret's Hospital, Hammond, with a bed capacity of 30, founded in 1898, obtained nurses from St. Elizabeth Hospital,

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¹ Dunn, Jacob Piatt, *Indiana and Indianans*, The American Historical Society, Chicago, 1919, vol. 2, p. 804.

² Kemper, G. W. H., *A Medical History of the State of Indiana*, American Medical Association Press, Chicago, 1911, p. 71.

³ Morrison, Olin D., "Indiana's Care of Her Soldiers in the Field, 1861-1865," *Indiana University Studies*, Indiana University, Bloomington, Indiana, 1926, vol. 12, no. 66-68, p. 277-302.

⁴ Dunn, Jacob Piatt, *Indiana and Indianans*, The American Historical Society, Chicago, 1919, vol. 2, p. 912.

⁵ The name was changed from Indianapolis City Hospital to Indianapolis General Hospital in 1947.

⁶ Documents, Good Samaritan Hospital, Vincennes.

⁷ Records, Indianapolis General Hospital, Indianapolis.

Lafayette. Protestant Deaconess Hospital, Evansville, with a bed capacity of 19, was opened in 1892. Professional nurses from Christ's Hospital, Cincinnati, Ohio, and Drexel Home Hospital in Philadelphia were secured. Union Hospital, Terre Haute, with a bed capacity of 18, was opened in 1892, and used inexperienced workers at first. Four years later two Deaconess Sisters from Bethesda Hospital, Cincinnati, Ohio, were secured. Other workers, both with and without previous experience in the care of the sick, were also used. Memorial Hospital, South Bend, with a bed capacity of 12, was opened in 1893 and one nurse and some women of the community cared for the sick.⁸

A few specific accounts relating to the establishment of some of these hospitals may show some of the hardships and difficulties encountered. The following is a description of the founding of St. Vincent's Hospital.

"April 27, 1881, four Daughters of Charity without possessions or funds, arrived in Indianapolis to found a Catholic Hospital. They came at the invitation of the Bishop of Indianapolis, Most Reverend Silas Chatard.

"The first day must have been one of mingled emotions for the Sisters. At the very hour of their arrival, a circus was parading the town. The spectators, who had never seen a Sister of Charity with her white-winged cornette, supposed them to be new and novel entertainers brought along with the other itinerant attractions. The surrey in which the Sisters rode was loudly cheered—cheers which the Sisters took smilingly, and with perfect self-possession.

"When they reached their destination, the rooms that they were to occupy were not in readiness. Indeed, no preparations had been made. Bishop Chatard, who greeted them at the church, took pine boxes from the basement and made a fire that the Sisters might cook their first meal in Indianapolis. Without doubt, it was just such situations that St. Vincent de Paul anticipated when he urged Sisters of Charity to be gay in meeting difficulties. . . .

"The first St. Vincent's Hospital occupied a part of the old St. Joseph's Church and Seminary Building located on Vermont and Liberty Streets. The building had no furnace, and the Sisters carried coal up, and ashes down, three flights of stairs. They used kerosene lamps because of the cost of gas, and they labored amidst a host of other inconveniences."⁹

On January 1, 1884, the old building previously occupied by St. Anthony's Hospital, Terre Haute, was closed and a new building was opened.

"The first patient admitted to the ward of the new hospital was a tramp. As the sister on night duty made her rounds she noticed that the patient had unusual symptoms but the dim light of the lantern she carried prevented her from detecting the nature of the case. Towards morning a doctor was called and, to the consternation of all, the patient was pronounced a smallpox case. The ward was closed and disinfected and the tramp was taken to the pest house. Smallpox patients received no real nursing care, so George Plantett, a man around town who had had the disease, was hired to take care of the case. Under these conditions it is not surprising that smallpox often proved fatal."¹⁰

⁸ Reports received from the hospitals listed. Information obtained mostly from early records and accounts given by individuals.

⁹ *Golden Jubilee 1897-1947*, St. Vincents Hospital School of Nursing, Indianapolis, May 20, 1947, p. 7.

The following is a description of the first days at the Union Hospital, Terre Haute.

"The Union Hospital started with a two-story frame residence on North Seventh Street when it was then the edge of the city with no side-walks and only a single buggy track through the grassy street. The first patient was admitted in August, 1892.

"There were few beds and only a few doctors to do the work. Much of the help was voluntarily donated. There was a tub and washboard in the shed in the rear which was the laundry. A small cook stove sufficed for the meals, for hot water for the laundry, and for all the needs of patients. The two small wards had heating stoves in the centers of the rooms, while the private rooms were luxuriously supplied with coal fire places. Essie Roach was the handy man, engineer, repair man, pharmacist, and floor and operating room orderly for which he received the magnificent sum of \$25.00 a month. He, plus a cook and a laundress at \$15.00 a month, and one maid at \$10.00 a month made up the entire pay roll. In those golden days the utilities, water, electricity, gas, ice and coal were all donated. The ward rates were as low as \$5.00 a week, with the private rooms commanding \$10.00 a week. One deluxe room bore the tremendous weekly rate of \$15.00."¹¹

Sister Leonine, sole survivor of the four Sisters of the Holy Cross who opened St. John's Hickey Memorial Hospital, Anderson, on June 9, 1894, died in May, 1947. The *Anderson Herald*, in reporting her death, published parts of letters written by her for the golden jubilee of the hospital. They relate some of the events which up to that time had not been published.

Sister Leonine and Sister Gonzague were sent from the mother house to assist in transforming the Hickey homestead into a hospital. They arrived on May 21, 1894. Sister Leonine's account of the events shows some of the problems encountered.

"I taught at St. Mary's School in the morning, and cleaned the house in the afternoon. The house was in terrific condition. There were cobwebs from one room to another. There were two rooms without any windows. . . . Under the carpets . . . were pounds and pounds of straw. . . . We had a great struggle to provide for ourselves and the patients, and there were no modern conveniences. The patients brought their own beds and everything they could to help out."¹²

In spite of the hardships, the doors of the hospitals were opened and a new era of medical and nursing care had begun. The list of early hospitals is not intended to be complete, but is used as a sampling to show the trend in securing professional or non-professional workers in the early hospitals. The trend was to have a professional nurse in charge of nursing service. Later, as schools of nursing became more numerous when hospitals were developed, nurses for actual care of

¹⁰ Peters, Sister M. Rosanna, *The History of the Poor Sisters of St. Francis Scraph of the Perpetual Adoration 1875-1940*. Unpublished Doctor's dissertation, Department of History, Indiana University, Bloomington, Indiana, August, 1944, p. 50.

¹¹ *The Union Hospital 1910-1941*, Union Hospital, Terre Haute, 1941, p. 5.

¹² "Sister Leonine's Death Recalls Early Days at Hospital," *Anderson Herald*, Anderson, Indiana, May 27, 1947.

patients were secured from the schools of nursing in Indiana or from schools in other states.

The fact that the early hospitals were small is significant when considering the functions of the nurses in some of the early hospitals. Although the functions of the nurses varied in the different institutions, the total range of duties encompassed a wide variety of activities. Some care was given relating to the personal hygiene of the patient, which consisted mainly of giving the bath to those patients too ill to care for themselves. The time given to housekeeping responsibilities in various hospitals ranged from 25 per cent to 75 per cent. Nurses were often responsible for the daily laundry, which in many situations entailed heating the water on the stove and settling down to business with the wash tub and wash board. After the ironing, done with an old hand iron, came the mending. The scrubbing, cleaning, and dusting of the hospital were other tasks to be done. The nurses also prepared and served the meals. In some of the more "progressive institutions" the nurses only assisted with these housekeeping duties. St. John's Hickey Memorial Hospital, Anderson, reported that nurses were required to care for the cows and chickens owned by the hospital. Office and switchboard duties were often part of the routine. Only occasionally was the nurse expected to administer the therapeutics or diagnostic treatments which today are one of the major functions of the bedside nurse. These treatments usually included the dressing of wounds; application of fomentations, poultices, cups and leeches; the administration of enemas and irrigations; and the administration of "remedies."¹³

In general, the ratio of nurse to patient seemed to be between one to ten and one to twenty. The working hours per week varied from 50 to 84, with the average working day in some hospitals reaching 14 hours. In 1883, at the Indianapolis City Hospital, the practice was for the patients to care for each other after the nurses retired for the night.¹⁴

Some of the early hospitals made a distinction between the nurse's functions and the lay worker's, so that much of the responsibility for housekeeping, laundry, cooking, and similar duties was assigned to persons other than nurses. This trend became more evident in the beginning of the twentieth century.

Gradually the functions of the institutional nurse have changed until today, although she is still burdened with routine duties which could be delegated to others, her major responsibility is nursing care, which involves giving the patient the personal care necessary to make him comfortable, anticipating his needs, and teaching him those

things helpful in attaining and maintaining a healthy state of living. It also includes the administration of treatments and medications and the supervision of co-workers who assist in giving care to the patient. Many treatments given in the modern hospital necessitate the use of complicated equipment and apparatus which must be understood by the nurse if she is to use it safely for therapeutic purposes. Desirable reactions as well as untoward symptoms must be known. Careful observation and recording of symptoms and reactions are necessary to safeguard the patient and furnish the doctor with the information needed to evaluate the results. The observation of symptoms is a continuous process and, since the doctor spends a limited amount of time with the patient as compared with the time spent by the nurse, he finds a complete, accurate record of the symptoms and reactions a valuable aid in formulating the plan of treatment.

Some of the treatments the nurse performs today include: administering oxygen therapy and diathermy; taking blood pressure; assisting the doctor with the administration of intravenous infusions; caring for patients with suction siphonage; caring for patients in respirators; changing aseptic dressings; giving nasal feedings; caring for babies in incubators; and administering hypodermic and deep muscular injections, and oral medications.

A knowledge and skill necessary to perform safely these more scientific and complicated procedures require ability and professional preparations of a high caliber. Such a background of knowledge and experience is a marked contrast to that of the early nurse.

A sampling of the bed capacity of some of the present-day hospitals will indicate the growth which has taken place: Indianapolis General Hospital, 738 beds; St. Vincent's Hospital, 460 beds; St. Joseph Hospital, South Bend, 232 beds; St. Anthony's Hospital, Terre Haute, 185 beds; St. Margaret's Hospital, Hammond, 315 beds; Protestant Deaconess Hospital, Evansville, 300 beds; Methodist Hospital, Indianapolis, 712 beds; Indiana University Hospitals, Indianapolis, 646 beds; Union Hospital, Terre Haute, 210 beds; St. John's Hickey Memorial Hospital, Anderson, 290 beds; Methodist Hospital, Gary, 265 beds; Memorial Hospital, South Bend, 251 beds; Lutheran Hospital, Fort Wayne, 240 beds; and Ball Memorial Hospital, Muncie, 247 beds.

The provision of adequate nursing service for these and the many other hospitals in Indiana presents a major problem. A well organized nursing service staff is necessary in each hospital. The general pattern includes a Director of Nursing Service who sometimes serves as the Director of the School of Nursing if the hospital maintains such a school. The supervisors are usually in charge of a hospital division, such as the obstetric department, pediatric department, or medical department. A head nurse functions as the manager

¹³ Reports received from the hospitals listed. Information obtained mostly from early records and accounts given by individuals.

¹⁴ Rice, Thurman B., "The Origin and Development of the City Hospital," *Indiana State Board of Health, Monthly Bulletin* 50:95, April, 1947.

of a unit within the department and is responsible for coordinating the activities of related departments of the hospital and the activities of the personnel within the unit toward providing good nursing care for the patients in the unit.

General staff nurses, student nurses, if there is a school, and nurse's aides, usually prepared through in-service-programs, provide bedside nursing care under the direction of the supervisor and head nurse.

The following personnel practices relating to work hours and salary are quite generally observed today. The nurses are on duty approximately 44 to 48 hours a week, with at least one free day. The average day is eight hours in length and this time is given in unbroken service, following the pattern of 7 A.M. to 3 P.M.; 3 P.M. to 11 P.M.; and 11 P.M. to 7 A.M. The average monthly salary for the supervisor ranges from approximately \$180.00 to \$220.00. The salary for the head nurse and general staff nurse is usually a little less.

Hospitals, both veteran and civilian, are increasing in number and capacity, and are handicapped by the growing demand for more nurses.

In 1947 there were 9,222 nurses registered and living in Indiana. On December 31, 1947, there were 2,239 students in the schools of nursing in Indiana. Although there are more students in the schools now than there were five years ago, and although more have been graduated in the intervening years than ever before in a comparable period of time, the need for nurses is very acute.

Several factors have influenced this demand. Modern therapeutic treatments are time consuming. Time is necessary to teach the patient, satisfactorily, certain procedures essential for his safe care upon his return home. This is becoming increasingly important with the trend toward shorter periods of hospitalization. The decrease in the length of hospitalization in turn makes a more acute service, which, to complete the cycle, necessitates more nursing care per patient. In such expanding fields as psychosomatic medicine, the nurse needs to spend sufficient time with the patient to learn his problems and observe manifestations. Nurses specially prepared in psychiatric and tuberculosis nursing are being sought by special hospitals devoted to these fields. Industries have recognized the advantages of employing nurses and are utilizing more nurses in this area each year. Doctors, because of an increase in the number of patients, are employing more nurses in their offices and clinics. The expansion of community health services and the new awareness on the part of the public concerning health needs and the prevention of disease have contributed toward the demand for more public health nurses and school nurses. The demand for the nurse in private practice is also very great due to such factors as crowded hospital conditions which make it necessary for some patients to remain at home, the lack of adequate nursing service staff in some institutions, and the

improved economic status of a large number of persons. All these factors tend to affect nursing service in hospitals.

The Nurse in Private Practice

Nursing care given to an individual patient in the home or in the hospital is one of the oldest types of nursing service. As nurses were graduated from the early nursing schools in Indiana it was natural for them to enter this area of nursing service, since the personal satisfactions were great and other opportunities were relatively few.

A registry for private duty nurses was operated by the Flower Mission and Training School for Nurses, Indianapolis, in 1890. Registered nurses received \$15.00 per week, or \$2.50 per day. One of the regulations stated that "when taking care of a nervous patient, day and night, though the nurse may sleep, it is better for both patient and nurse that she have some time for exercise in the open air, apart from the patient." Student nurses were sent into homes as private nurses. The student was required "to always bring back with her a report of her conduct and efficiency, from the family of her patient, and from the medical attendant."¹⁵

One of the early private duty nurses was Miss Frances Ott, who was graduated from the Flower Mission and Training School for Nurses in 1886 and entered private duty in 1888. Miss Ott was the first chairman of the Private Duty Section which the American Nurses' Association organized in 1912.

Miss Ott stated that each private duty nurse was required to provide her own medicine glass and the patient's bedside call bell. She described the Ermich thermometer which was used during this period. It was round like a watch and was used in the axilla or on another surface of the body. The indicator moved in a circle like a weather indicator. There was a snap on the stem to bring indicator back to normal after it had registered the temperature. It registered only those temperatures above 100 degrees F. The thermometer cost ten dollars in 1889.¹⁶

Registries were established by other hospitals in Indiana and, although variations occurred and fees were different, the general plan was the same. Later, under the direction of the Indiana State Nurses' Association and through the efforts of the district associations, official registries were established in some localities. At present there are four official registries, called Nursing Service Bureaus,¹⁷ operating in Indiana. They are located at Fort Wayne, Gary, Indianapolis, and Terre Haute.

As late as 1930 the private duty nurse often worked 20 hours a day, getting what little rest she

¹⁵ *Annual Report of the Flower Mission and Training School for Nurses, Indianapolis, Indiana, 1890*, p. 18.

¹⁶ Ott, Frances, "What We Used Fifty Years Ago," *The American Journal of Nursing* 39:140, February, 1939.

¹⁷ Records, Indiana State Nurses' Association.

could at times when the patient was resting or when relatives or friends of the patient would relieve her. A "share the work" campaign, which started during the 1930 depression, when hundreds of private duty nurses were unemployed, resulted in a permanent plan for shorter hours. Through the nursing organizations and the nurses' official registries, the hours of service were reduced to 12 a day and later to eight-hour service, which is the policy today. The present charge for eight-hour service varies from \$8.00 to \$10.00 a day according to the nature of the disease, and in some instances according to the time the service is given. The nurse on night or evening service may receive the higher payment.

There are several patterns of care in current usage which followed the changes in hours of service. Sometimes three nurses, working eight hours each, give continuous 24-hour service to the patient. Another patient may have one or two nurses for eight hours each at the time when the nursing care is most complicated. The cost, the patient's condition, and the availability of nurses are determining factors in regard to the number of nurses employed.

Another pattern sometimes used in the hospital today is known as group-nursing. One nurse in private practice may give nursing service to two or three patients in the same or adjoining rooms. The total cost per day is greater, but the cost per individual patient is somewhat less. This pattern is useful when an insufficient number of nurses is available for each patient. The change in functions of the nurse in private practice parallels that of the institutional nurse.

The proportionate number of nurses in private practice has gradually decreased as the opportunities for nurses in different areas have expanded. Private practice remains, however, as one of the major areas of nursing service. In 1947 there were 1,925 registered nurses in Indiana engaged in private practice.¹⁸

Public Health and Related Nursing Services

The trends and development of public health nursing in Indiana follow the general trend of its development in the United States. In 1893 Miss Lillian Wald organized the Nurses' Settlement in East Side New York and introduced a new area of nursing to the people of that locality. In 1902 school nursing was established by the Henry Street Settlement, and in 1910 the first public health nursing course was established at Teachers' College, Columbia University, New York, under the direction of Miss Adelaide Nutting. The National Organization for Public Health Nursing was founded in 1912.

The members of the Flower Mission, Indianapolis, recognized the need for visiting nurses in 1885. Mrs. Mary Mays was asked to study the needs of

the families reporting to the City Dispensary. The reports showed a great need of education in the care of the sick in the homes of the Flower Mission patients. Sanitary conditions were bad, and a trained nurse was needed to make visits to the families and give instruction and care. A young English medical student, Miss Henley, was the first public health nurse to be employed by the city.¹⁹ She was subject to calls from the City Dispensary physicians and from the ladies of the Flower Mission. The care given was under the supervision of the physician, and the nurse was expected to prepare special diets and as far as possible to inculcate habits of order and cleanliness in the home.²⁰

Miss Abbie Hunt (later Mrs. Peter Bryce), the first Superintendent of Nurses at the Indianapolis City Hospital, urged the development of a Public Health Nursing Association during the first decade of the 1900's. Under her leadership the Graduate Nurses' Association raised money to pay the first month's salary of Miss Belle Emden, who was employed to give public health nursing services. For some time after that her salary was paid by the Women's Department Club of Indianapolis. The Indianapolis Public Health Nursing Association was organized in 1912 and incorporated January 4, 1913.²¹ Miss Beatrice Short was appointed Superintendent of the Association in September, 1929, and has served in that capacity since that time. In 1947 the name of the Association was changed to the Visiting Nurse Association of Indianapolis.

The Metropolitan Life Insurance Company employed nurses who gave home service, and a few nurses were employed in the schools of Indianapolis. Miss Blanche Neff was employed in 1908 to work with those families in the city where there was a case of tuberculosis.²² In February, 1919, the State Tuberculosis Association employed Miss Pearl Stanton to go into rural areas. Her services were paid for by the county in which she worked and she continued in each county only as long as there were funds available for her employment.²³

The problem of caring for the sick in the homes was common throughout Indiana, and hospitals, nurses, and community groups struggled to develop a plan to meet these needs.

Since 1912, Red Cross chapters have sponsored public health nursing services in more than half the counties in the United States. It has been the constant purpose of the Red Cross to encourage the

¹⁹ Rice, Thurman B., "The Flower Mission," *Indiana State Board of Health, Monthly Bulletin* 47:261, November, 1947.

²⁰ *Annual Report of the Flower Mission and Training School for Nurses*, Indianapolis, 1890.

²¹ Rice, Thurman B., "Beginnings of Public Health Nursing in Indiana," *Indiana State Board of Health, Monthly Bulletin* 45:37-40, February, 1945.

²² *Ibid.*

²³ Records, Indiana State Tuberculosis Association, through letter to author, July 31, 1947, from Mr. Murray A. Auerbach, Executive Secretary of the Indiana State Tuberculosis Association.

¹⁸ Records, Indiana State Board of Examination and Registration of Nurses.

development of public health nursing services, to demonstrate the value of such services, and to assure their permanence by ultimate transfer to the community.²⁴

Since there was, in Indiana, no bureau or division of public health nursing within the State Department of Health, the American Red Cross and other voluntary agencies, notably the State Tuberculosis Association, assumed the responsibility for going ahead with their own plan of organization and development in this state.²⁵

The first state supervising nurse, Miss Ina Gaskill, was employed in 1919. The American Red Cross paid her salary and provided office space in the Lemcke Building, Indianapolis, which at that time was the headquarters of the State Red Cross. In March, 1920, a second supervising nurse, Miss Annabelle Peterson, was employed, because the organization of county public health nursing services was progressing very rapidly.²⁶

In May, 1920, an agreement between the State Board of Health and the American Red Cross was reached regarding public health nursing. The agreement, which follows, was obtained from the 1920 *Annual Report* of the Nursing Division of the Indiana State Board of Health:

"The Assistant Director of the Bureau of Public Health Nursing, of the American Red Cross for Indiana, Miss Ina M. Gaskill, and her assistant, Miss Annabelle Peterson, will have offices in the State Board of Health. The Director of this department will also be Director of Public Health Nursing for the State Board of Health.

"The purpose of this department is to stimulate interest in Public Health Nursing work, to standardize public health work throughout the State, to serve as a clearing house, to plan a system of State records, and to help interest and prepare nurses in the field. The greatest stress will be placed on the county and rural public health nursing."

Although no law was enacted to create a division of public health nursing, the department as set up was recognized as official, with a director and assistant director responsible to the secretary of the State Health Department. Miss Peterson served in the dual capacity of assistant director of public health nursing in the State Department of Health and as nursing field representative for the American Red Cross, until she was transferred to Headquarters of the Washington, D. C., division in March, 1924. By this time the Division of Public Health Nursing was sufficiently well established to warrant the withdrawal of the American Red Cross from the State House.²⁷ In 1922 there were 242 public health nurses employed in the State.

Miss Isabelle Glover served as Director of the Division of Public Health Nursing, Indiana State Board of Health, from 1924 to 1926. Miss Beisel was her assistant until 1925, when Miss Eva MacDougall became her assistant. When Miss Glover

resigned, Miss MacDougall became acting director and served as such until she was appointed director in April, 1927. Miss MacDougall was director until July, 1942. Upon her resignation, Miss Ethel Jacobs, the present director, was appointed.²⁸

From 1937 through 1946, the Indiana State Board of Health offered and granted financial assistance to many counties in the state for the development of county public health nursing services. These grants were offered on a temporary basis from year to year as a means of demonstrating to the public the value and benefits of this type of public health service. Some agencies received their total budget from the Indiana State Board of Health, while other agencies supplemented their budget from State Board funds. In June, 1946, Dr. L. E. Burney, State Health Commissioner of the Indiana State Board of Health, advised the counties that state funds were not available for 1947, and that it would be necessary for the counties to assume the entire cost and make necessary appropriation if the nursing services were to be continued.²⁹

As a part of its 1947 activities, the Division of Public Health Nursing gave continued consultation service to public health nurses throughout the state; developed and improved clinic facilities for venereal disease, well child, tuberculosis, prenatal and immunization; improved and assisted in family health counseling, which included bedside care; organized and promoted rural health committees, public health advisory councils, and full-time health units; gave direct and consultant service to local physicians, nurses, and school personnel on treatment and prevention of ringworm of the scalp; planned in-service training and held staff conferences on venereal disease and tuberculosis control, communicable disease, and school and adult health; and assisted with many other activities concerned with organization and administrative functions.³⁰

In 1947 there were 879 public health nurses employed in Indiana. Of this number, 30 were supervisors, 368 were staff nurses, 6 were employed in schools of nursing, 100 were supervising nurses in industry, and 375 were staff nurses in industry.³¹

NURSING EDUCATION IN INDIANA

Basic Professional Nursing Education

With the establishment of the first Indiana Training School for Nurses, at the Indianapolis Flower Mission in 1883,¹ nursing as a profession was born in Indiana.

The 65 years of growth of this profession parallels the phenomenal expansion of education, in-

²⁴ Summary of activities in the founding of public health nursing in Indiana, compiled from the files and sent by Miss Annabelle Peterson, American Red Cross, Washington, D. C., to the author, August 11, 1947.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ Informal statement from Miss Eva MacDougall to the author, March 6, 1948.

²⁹ Copy of letter from Dr. L. E. Burney to Mr. Donald Smith, Auditor, Lawrence County, Bedford, Indiana. Information affirmed.

³⁰ *Annual Report*, Division of Public Health Nursing, Indiana State Board of Health, Indianapolis, Indiana, 1947.

³¹ *Ibid.*

dust, transportation, communication, and science, including medical science. Developments occurring in these areas exerted marked influence on the nursing profession and helped in bringing about its rapid growth, which has been in response to the needs of society.

It was the need of society for nursing care which stimulated interest in the establishment of the first nursing school in Indiana. In 1883 the preparation of professional nurses was still a new trend in the United States, and thoughtful consideration was given to the new venture by physicians and hospital authorities. A statement by Dr. W. N. Wishard, Superintendent of City Hospital, Indianapolis, concerning the proposed project was published in the 1883 *Nursing School Bulletin, Flower Mission Training School for Nurses*.

"I visited the Cook County Hospital, Chicago, last week to investigate the practical working of the training school system, with a view towards its adoption in the Indianapolis City Hospital if found satisfactory. A comparison of the work done in the wards not under care of the training school nurses and those under their care, presented a most complimentary showing for the latter. The physicians with whom I conversed gave their unqualified indorsement of the superiority of the nursing done by the training school nurses. The plan is, in my judgment the most practical, therefore the best, that could be adopted for furnishing the public with trained and disciplined nurses. I am ready for its application in all the wards of the Indianapolis City Hospital as soon as the school is organized and in working order."²

Other physicians cordially endorsed the plan and pointed out the need for educated qualified nurses to care for the sick.³

The first class consisted of nine students, five of whom were graduated. The first student accepted was Miss Margaret Iddings, and she is considered the first graduate nurse in Indiana.⁴ The course was two years in length and included the following instruction: the temporary treatment, in the absence of the physician, of such emergencies as poisoning, hemorrhage, syncope, convulsions, and suffocation; the inspection of discharges from the body; the care of lying-in women and of young children; the dressing of blisters, burns, ulcers, wounds, and fractures; the application of fomentations, poultices, cups, and leeches; the administration of enemas and irrigations, and bathing the patient in bed; the management of appliances for uterine complaints and the use of the catheter; the administration of remedies; the hygienic care of the sick room; the management of helpless pa-

tients; the prevention and dressing of bedsores; friction and massage; the accurate observation of the state of the secretions, appetite, mental condition, sleep, and condition of wounds; the effect of diet, stimulants, or medicines; temperature, pulse, and respiration, and the recording of the same; the management of convalescents; the general outline of anatomy, situation, and boundaries of organs; physiology; practical instruction at the bedside; the making and changing of beds; the cleaning and disinfecting utensils; and the preparation and serving of food and drinks for the sick.⁵ The *Nursing School Bulletin* stated that:

"The teaching will be given by visiting and resident physicians and surgeons at the bedside of the patients, and by the Superintendent and Head Nurses. Lectures, recitations, and demonstration will take place from time to time and examinations at stated intervals."⁶

It was possible for any woman who desired to obtain the benefit of the instruction given in the school, but who did not intend to follow the vocation of nurse, to attend the course by paying in advance a fee of \$10.00 for the session. Such persons were not required to pass the examinations.⁷

Several schools of nursing were in operation over the state by the close of the nineteenth century, among which were the following present schools of nursing: the Welborn Memorial Baptist Hospital⁸ School of Nursing, Evansville, opened in 1894; student admissions were "staggered," that is, students were permitted to enter the school at any time. Protestant Deaconess Hospital School of Nursing, Evansville; St. Vincent's Hospital School of Nursing, Indianapolis, and Memorial Hospital⁹ School of Nursing, South Bend, opened in 1896; St. Elizabeth Hospital Training School for Nurses, Lafayette, opened in 1897; Lafayette Home Hospital Training School for Nurses and St. Stephens, now the Reid Memorial Hospital School of Nursing, Richmond, opened in 1899; and Union Hospital School of Nursing, Terre Haute, opened in 1900.

In these early Indiana schools of nursing the number of students admitted in the first class varied from one to ten. High school graduation was not required. Some of the schools required the prospective students to have a physical examination by the family physician, others required an examination by the nursing school physician, while others did not require any examination. The lower age requirements varied from 16 to 21 years of age, with the majority requiring the student to be

¹ Records, Indianapolis General Hospital School of Nursing, Indianapolis, Indiana. The school, started by the Flower Mission, was taken over later by the Indianapolis City Hospital. The name was changed to Indianapolis General Hospital School of Nursing in 1947.

² *Nursing School Bulletin, lower Mission Training School for Nurses*, Indianapolis, 1883, p. 8.

³ Statements made by the physicians may be found in the *Nursing School Bulletin, Flower Mission Training School for Nurses*, 1883.

⁴ Records, Indianapolis General Hospital School for Nurses.

⁵ *Nursing School Bulletin, lower Mission Training School for Nurses*, 1883.

⁶ *Ibid.*, p. 12.

⁷ *Ibid.*, p. 12.

⁸ In 1894 the official title of the hospital was Evansville Sanitarium. It was later changed to Walker Sanitarium, Walker Hospital, Welborn Walker Hospital, and, in 1944, to the present title, Welborn Memorial Baptist Hospital. It will be referred to in this history by the present title.

⁹ Present title.

21 upon admission to the school. The practice was quite general for students to receive board, room, and laundry, and a small "allowance" of approximately \$10.00 a month. One school reported the students were paid ten cents a day.¹⁰

The lack of adequate records in the early schools makes it difficult to obtain information regarding the program of studies. In some instances available records go back only to a time several years after the school was opened. Some schools recorded the subjects included but did not indicate the number of hours of instruction. The total number apparently ranged from 60 to 100 hours. In general, the following courses were taught: anatomy and physiology, medical and surgical nursing, ethics, obstetrics, nursing arts, nursing of children, and sometimes dietetics.

After four months in the nursing school, students spent from 50 to 70 hours a week on the clinical division in addition to classes. Students sometimes remained on night duty for two months and worked 12 hours a night. The typical day was 12 hours long and class periods were often added to that time. Evening classes were not uncommon.

The nursing functions of the students varied from school to school. The following is a summarization of the functions of student nurses as listed by the early schools. Not all items listed were common to all schools but each was listed as a function by at least one school. The functions were: assisting with laundry, cooking, scrubbing, cleaning, sewing; office and switchboard duties; assisting in pharmacy, laboratory, and with non-technical duties in the x-ray department; giving approximately 25 to 50 per cent of time to house-keeping responsibilities; giving care relating to personal hygiene of the patient; and administering medicines and hypodermics and changing dressings.¹¹

The most rapid expansion of nursing schools in Indiana occurred in the first two decades of the twentieth century. Hospitals were increasing and nurses were needed. In 1908 there were more than 70 hospitals and sanitoriums in Indiana, 38 of which were operating schools of nursing. Six of the hospitals with schools had a bed capacity of 10 or fewer.¹²

It was evident that some kind of control and standardization was necessary. Some other states faced with a similar problem had established registration laws for nurses.

The Indiana State Nurses' Association was organized on September 3, 1903, and became incorporated March, 1904. One of the first tasks of the new organization was to secure state legislation

controlling the examination and registration of nurses. The legislative Act creating a Board of Examination and Registration of Nurses was passed by the State Legislature February 27, 1905. Miss Edna Humphrey was appointed president of the Board.¹³

Dr. Maude McConnell, one of the charter members of the Indiana State Nurses' Association, gave several interesting facts connected with the law.

"Indiana was the seventh state to have registration for nurses. It was the first law of its kind passed west of the Appalachian Mountains; it was the first law for women put through by women."

The first Board of Nurses appointed by the Governor, Frank Hanley, was composed of a Canadian nurse, Miss Menia S. Tyle, Indianapolis; Miss Edna Humphrey, Crawfordsville; Miss Lizzie M. Cox, Elizabethtown; Miss Isabella Gerhart, Lafayette; and Dr. Eva S. Sammon, Indianapolis.¹⁴

Miss Lizzie Morris Cox, first inspector of training schools in Indiana, gave the following account of this important period:

"In December, 1906, we had our first meeting for registering nurses. It was interesting to see many nurses who were not eligible to register try in many ways to come under the requirements of the law. Some were very indignant but we held strictly to law. After the first meeting in December we found the need for a uniform curriculum. We divided the different subjects among the Board members and each prepared her own list of questions for the State Board Examination. Some schools did not have the full required courses, which created a problem. Schools were sending nurses out as fully equipped for nursing, and we could not say they were not capable of giving the public the best that was required of them. In 1908 the Board sent me over the State to inspect the work of the different hospitals. I visited every hospital, sanitarium, and place where nursing was done. Some of the places had only two beds. I was received kindly in most instances while some treated me as an intruder and as though I was interfering where I had no business. Where there was a training school I found the superintendents very willing to co-operate with the Board. We placed before the schools a uniform curriculum to which they readily conformed, placing all schools on a three-year basis, where some had three and some two years of training. Two years after placing the curriculum before the schools we followed up our work. I visited only those hospitals that I found on my first visit would support training schools."¹⁵

Some of the present schools of nursing which were founded early in this century include: Lutheran Hospital School of Nursing, Fort Wayne, 1904; Ball Memorial Hospital School of Nursing, Muncie, 1906; St. Joseph Hospital School of Nursing, South Bend, 1907; Methodist Hospital School of Nursing, Indianapolis, 1908; Good Samaritan Hospital School of Nursing, Vincennes, 1908; St. John's Hickey Memorial Hospital School of Nursing, Anderson, 1909; Indiana University Training School for Nurses, Indianapolis, 1914; Good Samaritan School of Nursing, Kokomo, 1917; St. Anthony Hospital School of Nursing, Terre Haute, 1918;

¹⁰ Reports from the Schools of Nursing above listed.

¹¹ *Ibid.*

¹² Records of the Indiana State Board of Examination and Registration for Nurses.

¹³ Records, Indiana State Nurses' Association.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

St. Margaret Hospital School of Nursing, Hammond, 1919; St. Joseph School of Nursing, Mishawaka, 1919. The Methodist Hospital School of Nursing at Gary opened in 1923. The most recent school to be established in Indiana is St. Mary's College School of Nursing, which was organized as an integral department in St. Mary's College, Notre Dame, South Bend, during 1935. The first student was admitted in the fall of 1936.¹⁶ Other schools of nursing in Indiana at the present time are: St. Catherine Hospital School of Nursing, East Chicago; St. Mary's Hospital School of Nursing, Evansville; St. Joseph Hospital School of Nursing, Fort Wayne; and St. Mary's Mercy School of Nursing, Gary. The Bloomington Hospital School of Nursing, Bloomington, is not admitting students at this time.

In comparing the schools established in the last decade of the nineteenth and the first decade of the twentieth century, several changes are noticeable. The program of studies in the latter group included bacteriology and history of nursing fairly consistently, followed a little later by the addition of chemistry. The number of hours of instruction showed a marked increase. There was a great variation from school to school in the amount of time spent in the different clinical areas, namely: obstetrics, pediatrics, medical and surgical nursing, and diet kitchen. The time spent in the clinical nursing departments increased as the programs were expanded to three years.

A few of the early schools of nursing had one full time instructor who taught all the subjects. The more common practice was for the superintendent of nurses or the supervisor to teach the students. Many of the supervisors worked 84 hours a week, and the teaching of students was just another item added to their many duties. Some of the instructors were high school graduates but many were not, and only a few had special preparation beyond the basic professional curriculum.

The schools established from 1914 to 1923 showed greater standardization of instruction and clinical experience, as well as an increase in the number of hours of instruction. The existing schools were also raising their standards and improving their instruction.

One must not overlook the fact that World War I occurred in the latter part of the 20-year period between 1900 and 1920, when nursing schools were expanding so rapidly. Nurses had found their places in the hospitals and on the battle fields of France, and the urgent need for nurses both at home and abroad aroused interest and sent many young women into the schools of nursing. The influenza epidemic of this period increased the number of patients in the hospitals and the demand for nurses in the homes.

The results of some of the activities of the national nursing organizations influenced the schools of nursing in Indiana as well as other schools throughout the country.

The *Standard Curriculum for Schools of Nursing*, published by the National League of Nursing Education in 1917 and revised in 1927 and 1937, contributed toward an improved, more standardized curriculum in the nursing schools. The five-year study started by the Grading Committee of the National League of Nursing Education in 1926 was a far-reaching enterprise which aided the boards of nurse examiners in deciding on standards for schools of nursing and establishing minimum requirements.

The depression of the early 1930's had a marked effect upon nursing and nursing education throughout the United States. The Grading Committee studies had indicated a trend toward overproduction of nurses, and during the depression hundreds of nurses were unemployed. A large number entered institutional nursing and served as general staff nurses at very low salaries, sometimes \$30.00 to \$50.00 a month. Before this time, graduate nurses had not been used so extensively in this capacity by the hospitals. Hospital admissions decreased during this era of general unemployment, and many of the hospitals found it necessary to close some departments. As a result, the demand for nurses decreased, student enrollments in the United States decreased 20 per cent from 1932 to 1935, 500 small schools were discontinued, and the average size of the remaining schools increased.

During 1932 three Indiana hospitals closed their schools of nursing, and a fourth, which was removed from the accredited list of nursing schools, closed early in 1933. In March, 1933, there were 29 accredited schools of nursing, with a total student enrollment of 1,653. Eight of these schools were connected with hospitals of fewer than 100 beds, 12 were connected with hospitals of between 100 and 200 beds, and nine were connected with hospitals of over 200 beds. A total of 853 students entered the schools of nursing in Indiana in 1931, and 605 students entered in 1932. All of the 29 schools required a high school diploma for matriculation, and preference was given to students in the upper third of their high school classes. Mental tests were used routinely in six schools. The hours of classroom teaching given in 22 schools ranged from 900 to 1,300 hours. The classroom instruction in the other seven schools ranged between 600 and 900 hours. Twenty-one of the schools had a full-time instructor, and the faculty of 12 schools included instructors from adjacent colleges. Four schools of nursing had a university cooperative plan, namely: Indiana University Training School for Nurses, Indianapolis, with Indiana University, Bloomington; Indianapolis City Hospital School of Nursing, Indianapolis, with Butler University; Methodist Hospital School of Nursing, Indianapolis, with DePauw University; and Ball Memorial

¹⁶ Information received from the schools of nursing listed above.

School of Nursing, Muncie, with Ball State Teachers College.¹⁷

In some situations, clinical experience which was not available in the home school was obtained through affiliations. Ten schools affiliated with other institutions for pediatrics and medicine, one for psychiatry, and one for communicable diseases. Ten schools gave students experience in public health nursing through affiliation with visiting nurse associations or other public health organizations.¹⁸

In 1933 eight schools still required students on night service to work 10 to 12 hours a night. In other schools the hours of service were from eight to nine hours, although six schools had an eight-hour plan for both day and night service. All schools gave at least one half day off a week and one fourth of the schools gave two half days a week. The majority gave only two weeks vacation a year. Allowance, as it was then called, had been discontinued in 15 schools. Three of these schools were using this money to pay the salaries for additional nurses for staff duty, which would permit shorter hours for students, and four schools used it to pay additional instructors.¹⁹

Four schools included an X-ray of the chest in the first routine examination. All schools either required a certificate of vaccination for smallpox and typhoid fever or had the students vaccinated after admission to the school. A record of the students' weight was kept in all schools.²⁰

In 1938 the Laura A. Kindig Training School at Goshen and the Marion General Hospital Training School at Marion were discontinued. There were then 28 accredited schools of nursing in Indiana, which is the present number. The 27 schools of nursing now in operation and the one inactive school have been previously listed.

A *Curriculum Guide for Schools of Nursing*, published by the National League of Nursing Education in 1937, placed higher optimum standards before the schools of nursing, and the minimum standards of the State Board of Examination and Registration of Nurses in Indiana were changed somewhat in 1941. Before these changes were put into effect, the United States entered World War II in December, 1941.

Graduate nurses from all areas of nursing entered the military service. Essential nursing services, which included administrative and instructional personnel in schools of nursing, were defined. Those nurses in essential positions were urged to remain in their positions. In June, 1943, there were 962 graduate nurses, including 382 staff nurses, employed in Indiana hospitals operating schools of nursing. Vacancies, including faculty and staff nurses, totaled 257.²¹ The shortage of

instructors, supervisors, head nurses, and staff nurses created a difficult problem for nursing school administrators. There was a constant demand for greater student enrollment, which was increased with the passing of the Bolton Act by Congress in 1943, which provided federal funds for student nurses, but there was also a constant depletion of essential personnel to teach the students.

By September, 1943, the Indiana schools of nursing had accelerated their programs to include within a 30-month period the minimum of required organized teaching and clinical experience.²²

As of September, 1943, there were 16 schools of nursing which affiliated with other institutions to supplement the required clinical experience. Nine schools offered elective affiliations in public health nursing and seven of these nine schools also offered elective affiliation in psychiatric nursing. Only five schools in Indiana were without affiliation.²³

With the close of World War II and a cessation of federal funds for new students entering schools of nursing, there has been a slight decrease in student enrollment. Many of the schools need additional staff nurses for bedside care as well as qualified instructors for teaching the students. The schools are in the process of de-acceleration, although some students in the schools today are completing their programs under the United States Cadet Nurse Corps system of acceleration.

At present, six schools of nursing have an interchange of credit with colleges or universities leading toward a baccalaureate degree.²⁴

The School of Nursing at St. Mary's College Notre Dame, South Bend, offers a five-year program leading to the degree of Bachelor of Science in Nursing. Students in this program receive clinical experience in surgical, medical, obstetric, orthopedic, eye, ear, nose, and throat nursing at Mount Carmel Hospital, Columbus, Ohio; pediatric nursing at Children's Hospital, Columbus, Ohio; tuberculosis nursing at Franklin County Tuberculosis Sanatorium, Columbus, Ohio; public health nursing at the Columbus Instructive District Nurses' Association, Columbus, Ohio; and psychiatric nursing at Toledo State Hospital, Toledo, Ohio. Following this experience, the students return to the college for the final semester in which courses in nursing education and electives are offered. Instruction in biological and physical sciences and in liberal arts precedes the clinical instruction.

Ball Memorial Hospital School of Nursing, Muncie, offers a four-year program leading to the degree of Bachelor of Science in Nursing Education from Ball State Teachers College. A three-year basic professional program is also offered for those electing the straight professional program.

¹⁷ Records of the Indiana State Board of Examination and Registration of Nurses.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*

²¹ *Ibid.*

²² *Ibid.*

²³ *Ibid.*

²⁴ Information concerning the program was received from the schools of nursing described.

The Protestant Deaconess Hospital School of Nursing, Evansville, offers a three-year program or a five-year cooperative degree program with Evansville College.

A cooperative plan has been developed between the Indianapolis General Hospital School of Nursing and Butler University, Indianapolis. A student who has acquired 100 hours of credit toward a B.S. or A.B. degree at Butler University may, upon completion of two years and four months at the nursing school, receive the B.S. or A.B. degree. By complying with this regulation a student would be able to obtain her diploma as a graduate nurse and her Bachelor's degree in five years and four months.

The Methodist Hospital School of Nursing, Indianapolis, offers a program leading to a Bachelor's Degree through an affiliation program with Butler University, DePauw University, Franklin College, Earlham College, Taylor University, and Evansville College.

The St. Elizabeth Hospital School of Nursing, Lafayette, is affiliated with St. Francis College, Fort Wayne, Indiana. Students desiring to combine an academic course with their nursing education, may after two years at the college and three years in the school of nursing, receive a Bachelor's degree and a diploma in nursing.

The Indiana University Training School for Nurses, Indianapolis, has temporarily waived the one year of college prerequisite because of conditions arising out of the war. However, a one-year program of general basic educational courses available on the campus at Indiana University, Bloomington, is recommended as a prerequisite for students wishing to enter the school of nursing.

The schools of nursing in Indiana are gradually developing curricula to include experience for all students in tuberculosis, communicable disease, and psychiatric nursing, as well as directing efforts toward providing for better integration of public health nursing. Six schools offer experience in psychiatric nursing, six in tuberculosis nursing, and thirteen in communicable disease nursing, and nine schools have an affiliation with visiting nurse associations.²⁵

The increase in the number of students in the schools of nursing in Indiana from 1913 to 1948 may be shown by sampling a few of those years. In 1913 there were 579 students in the nursing schools; in 1922 there were 1,089 students; in 1932 there were 1,710 students; in 1942, 2,123 students; in 1946, 2,912 students; and on December 31, 1947, there were 2,239 students enrolled in the nursing schools in Indiana.²⁶

It must be remembered that, as the number of students was increasing, the amount and quality

of instruction was improving. Additional hours of instruction in the biological and physical sciences, including anatomy, physiology, chemistry, and microbiology, became necessary as medical science advanced, bringing into common practice more technical nursing procedures. The advance of modern medicine called for more instruction in pharmacology and therapeutics, if the nurses were to observe and record the effects of the drugs. As community services and an awareness of social needs developed, more hours of sociology, social problems, and psychology were added to the nursing school curriculum. With an increased emphasis on the clinical areas, such as psychiatry, tuberculosis, obstetrics, and pediatrics, and new approaches to medicine and surgery nursing students needed more instruction in these areas also, if they were to function safely in the fulfillment of their responsibilities. There seems to be a recognition of the importance of incorporating public health nursing and health teaching throughout the basic curriculum in addition to teaching the course, Nursing and Health Service in the Family.

There is still a fairly wide range in the total number of hours of instruction offered in the schools of nursing in Indiana. The total number of hours required would average between 1,050 and 1,300 for the three-year curriculum. At present more consideration is given to the selection of students than heretofore, and a number of the schools use psychometric tests to aid in the selection. Pre-admission physical examinations, including chest X-rays, are required in all schools. Well-planned student health programs, including periodic examinations, are quite general. More attention is being given to desirable housing facilities and to plans for co-curricular activities for the students.

As of December 31, 1947, in schools of nursing in Indiana there was one director, school of nursing, for each school, and there were, in all, 15 assistant or associate directors, 91 full-time instructors and assistant instructors, and 40 supervisors and head nurses who assisted with teaching.²⁷ It is recommended that, when supervisors and head nurses serve in a dual capacity as members of the nursing service staff and also as members of the nursing school faculty because of teaching responsibilities, they be given a dual title to indicate both functions. In such cases their nursing school faculty title would be *clinical instructor* and *assistant clinical instructor*, respectively. Because this terminology has not been adopted in all the schools of nursing in Indiana, the nursing service titles of *supervisor* and *head nurse* were used in listing this group of instructors.

Today the average full-time instructor teaches three or four subjects, and averages 16 teaching hours a week. Her salary ranges from \$200.00 to \$250.00 a month.

²⁵ Records of the Indiana State Board of Examination and Registration of Nurses.

²⁶ *Ibid.*

²⁷ *Ibid.*

The increase in the number of hours of instruction and in the number of courses offered naturally created a need for more and better qualified instructional personnel. Although progress has been made, there are still many vacancies on nursing school faculties, due to lack of available properly qualified personnel.

ADVANCED NURSING EDUCATION

Indiana University, Bloomington.—A need for an advanced nursing education program in Indiana was recognized by nursing leaders in Indiana by the late 1920's. Several advanced programs had been developed in the adjacent states, but it was thought that more nurses would avail themselves of the opportunity for advanced preparation if it were made available in the immediate locality. Qualifications for nurses in specialized fields were being raised. Special qualifications for school nurses and public health nurses were under discussion. A definite need for qualified instructors and supervisors existed throughout the state.²⁸

Some of the nurses interested in the development of such a program were members of the Indiana Health Council. At the Council meetings they met Dr. W. W. Patty, then director of the Physical Welfare Training Department of the School of Education, Indiana University, who was interested in the preparation of school nurses and instructors of health and hygiene. Dr. Patty discussed the possibilities of an advanced nursing education program with Dr. Henry Lester Smith, then dean of the School of Education. They presented the matter to Dr. William Lowe Bryan, president of the University, and permission was secured to establish the program. Dean Smith requested that a committee be appointed from the Indiana State Nurses' Association to give consideration to the proposed curriculum, and in the summer of 1931, Miss Gertrude Upjohn, president of the Association, appointed the committee known as the "Committee on Proposed Courses at Indiana University." In 1933 the name was changed to the "Committee on Post Graduate Study and Education." The committee was dissolved in 1941.²⁹

The original program was directed toward the preparation of nurses for administrative, teaching, and supervisory positions in nursing schools and toward the preparation of nurses for public health nursing positions. The first official offerings of the nursing education curricula were in the summer of 1932. Four graduate nurses were enrolled, two in the field of administration, one in teaching in schools of nursing, and one in public health nursing. Since nursing courses were not offered on the campus, the students were permitted to take special courses in well-established University nursing programs and were given credit for the work done

there. In the summer of 1933 special nursing courses were offered in the three curricula. The instructors, the first in the nursing education program at Indiana University, were Mrs. Abbie R. Weaver, R.N., M.A., in public health nursing and Miss Clara Brooks, R.N., M.A., in teaching and hospital administration.³⁰

In 1934-1935 the first nursing extension instructors were employed and nursing courses were made available to the nurses of Indiana. That year there were 633 enrolled in nursing education courses and, in addition to this number, there were 150 nurses enrolled in other extension courses. In the seven-year period from 1933-1940, 55 classes were taught in eight centers in the state, with a total enrollment of 1,349. In the five-year period from 1941-1945, 40 classes were taught in 13 centers in the state, with a total enrollment of 969 students.³¹

In the year 1934-1935, Miss Gladys Sellew and Miss Virginia Jones taught the extension classes in nursing education. Miss Jones was appointed by Indiana University as full-time instructor and critic teacher in nursing education in 1935. The practice field was in Monroe County and Bloomington. In 1936 Miss Jones resigned and Mrs. Bessie F. Swan was appointed to fill the position as instructor and supervisor in public health nursing. Since there was no full-time instructor employed by the University in the field of hospital administration and teaching in schools of nursing, the services of part-time instructors were utilized. For extension courses, Miss Wilkie Hughes, Sister Amadeo, and Mrs. Opal Gilbert, all active in nursing education in the state, gave part-time services in the extension centers.³²

Mrs. Bessie F. Swan resigned in 1942 and Miss Frances Orgain, who had served on the staff for one year, assumed responsibility for the nursing education program.³³

In the beginning the program was in the Physical Welfare Training Department in the School of Education. Dr. W. W. Patty was Director of the Department and therefore responsible for the nursing education program. As the program expanded it seemed desirable to shorten the lines of administration, to give nursing education autonomy with other professional groups in the School of Education, and to give responsibility for the direction of the program entirely to a nurse educator. This was accomplished in 1944, and Miss Frances Orgain was appointed Director of Nursing Education.³⁴

Mrs. Eugenia K. Spalding became director of Nursing Education in the fall of 1946. At present (1948) there are six full-time and two part-time members of the nursing education faculty.

²⁸ Allen, Dotaline, "Nursing Education at Indiana University," *Indiana State Board of Health, Monthly Bulletin* 45:105, May, 1946.

²⁹ *Ibid.*, p. 105.

³⁰ *Ibid.*, p. 114.

³¹ *Ibid.*, p. 114.

³² *Ibid.*, p. 115.

³³ *Ibid.*, p. 115.

³⁴ *Ibid.*, p. 115.

There have been 103 nurses graduated with Bachelors' degrees from the program since 1936. At present (1948) the Division offers three major areas on the Bachelor's level. Area I includes curricula for preparing hospital nursing service personnel, Area II includes curricula for preparing public health nursing personnel, and Area III includes curricula for preparing school of nursing personnel. In 1947 a program was opened leading to the degree of Master of Science in Education with a major in Nursing Education. In the fall semester 1947 there were 95 students enrolled in the Division of Nursing Education.

The Division of Nursing Education is accredited by the National Organization for Public Health Nursing and is a member of the Association of Collegiate Schools of Nursing.

St. Mary's College School of Nursing, South Bend.—St. Mary's College School of Nursing, South Bend, has a department of nursing open to graduate registered nurses from any accredited school of nursing. The program offered leads to a Bachelor of Science degree in nursing and nursing education.³⁵

Many graduates of these programs in advanced nursing education are assuming positions of leadership in nursing education and nursing organizations in Indiana and elsewhere.

NURSING ORGANIZATIONS IN INDIANA

Indiana State Nurses' Association

With the earliest development of nursing service and nursing education in Indiana came the need for nurses to get together to discuss developments and needs and to plan for the future. As early as 1885 an organization for nurses, known as "The Nightingales," was formed in Indianapolis. In 1899 the Graduate Nurses' Association was organized, and later the Marion County Nurses' Association.¹ There may have been similar organizations in other sections of the state.

In 1903 the National Associated Alumnae of the United States and Canada, now the American Nurses' Association, appealed to Mrs. Gertrude Fournier, Superintendent of Hope Hospital, Fort Wayne, to organize a State Nurses' Association. The purpose of the proposed organization was "to enlarge and protect nursing education, nursing interests, and nurse practice." On September 3, 1903, the Indiana State Nurses' Association was organized and in March, 1904, became incorporated, with 65 charter members. Mrs. Fournier was the first president, and the headquarters was in Indianapolis.²

In 1905 this organization had 120 members, in 1915 the number had increased to 360, in 1925 there

were 1,120 members, in 1935 it had grown to 2,599, and in 1945 there were 4,438 members.

Sections have been developed as the needs and interests of nurses expanded. In 1917 the public health section was formed, and in 1920 the private duty section was organized. These were followed by the industrial nurses' section. The most recent addition is the institutional section, which was organized in 1947.³

In 1924 a headquarters office was established and Mrs. Alma H. Scott was appointed as executive secretary for the Indiana State Nurses' Association and educational director for the Indiana State Board of Examination and Registration of Nurses. Mrs. Scott served in this capacity until 1929 when Miss Eugenia Kennedy, now Mrs. Eugenia K. Spalding accepted the position. Mrs. Spalding served until 1931 when Miss Mary T. Walsh was appointed. Later that year Miss Helen Teal was appointed executive secretary of the State Nurses' Association and Miss Mary T. Walsh continued in the position of educational director of the Indiana State Board of Examination and Registration of Nurses.⁴ Miss Teal resigned in 1947 and Miss Nancy Scramlin, who was president of the Association, became acting executive secretary.

When the State Association was first organized, county units were established to carry on the activities of the organization on the local levels. In 1918 the county units were discontinued and four district associations were formed.⁵ Later this number was increased and at present there are 12 district associations in Indiana. These districts are organized, have committees, hold regular meetings, and further the activities of the State Association on the local level. Representatives of the districts compose the house of delegates at the annual meetings of the State Association. Some of the districts have special sections, which are units of the state sections.

The districts and the State Association send representatives to the biennial meetings of the American Nurses' Association, and such representatives from all other states and territories compose the House of Delegates of the national organization.

In 1946 the Indiana State Nurses' Association started the Counseling and Placement Service in cooperation with the program started by the American Nurses' Association. Miss Edwina MacDougall assumed her duties as consultant in the Indiana Professional Counseling and Placement Service, on August 1, 1946. In general, the scope and objectives of the program are to develop professional, education, and personal counseling and placement for registered nurses and auxiliary workers listed with professional registries, and

³ *Ibid.*

⁴ *Ibid.*

⁵ Meyers, Mary A., "Early History of Nursing in Indiana," *Indiana State Board of Health, Monthly Bulletin* 45:46, February, 1945.

³⁵ Communication from Sister Amadeo, Director, to the author, January, 1948.

¹ Records of the Indiana State Nurses' Association.

² *Ibid.*

also for those considering nursing as a professional objective. The counselor lists and compiles credentials of all nurses applying to the office for counseling and placement, collects records of employers' requests for positions to be filled, and works to establish good public relations and a nursing information program.

The service is growing in Indiana as nurses and the public learn of the counseling opportunities available and derive benefits from the service received.

Throughout the years the Indiana State Nurses' Association has served the nurses of Indiana and helped in solving the nursing problems of war and peace, expansion and depression. The nurses have given generously of their time and effort to serve as officers in the organization, to further its purpose, and to promote the welfare of the profession and its members.

Indiana State League of Nursing Education

In 1893 the American Society of Superintendents of Training Schools for Nurses was founded. It was the first national nursing organization, and its main objective was to maintain a universal standard of training for nurses. In 1912 the name of the organization was changed to the National League of Nursing Education and, as the name implies, it is concerned with nursing education.

In 1909 the Indiana State Society of Superintendents of Training Schools was formed and the name was later changed to Indiana State League of Nursing Education in harmony with the national organization.

This organization has been active in problems relating to nursing education in Indiana and has worked closely with the Indiana State Nurses' Association and the Indiana State Board of Examination and Registration of Nurses.

The League sponsors institutes on current topics and problems related to nursing education. The Indianapolis Local League, organized in 1947, functions as a unit within the state organization.

The Indiana State Board of Examination and Registration of Nurses

The explanation of the organization of the first Board of Examination and Registration of Nurses and the early developments were included in the discussion of nursing education.

The members of the State Board of Examination and Registration of Nurses are appointed by the Governor from a list of names of qualified nurses, submitted by the Indiana State Nurses' Association. The Board of five members functions as a division of the government of the State of Indiana. The original law provided for the appointment of two members for a term of one year each, two for a term of two years each, and one for a term of three years. All appointments, after the first Board, are for a term of three years. The officers of the Board are a president and a secretary.⁶ Officers are elected by the Board at each annual meeting, which is held in May.

The powers and duties of the board are prescribed by the law. In general, the duties of the board are: inspection and accrediting of schools of nursing; routine inspection of these schools to insure that the minimum requirements, as defined by law and outlined in the *Board Rules and Regulations for Accredited Schools*, are maintained; evaluation and approval of credentials, age, and educational qualifications of applicants for accredited schools of nursing; issue of certificates to license professional nurses and trained attendants; creation of rules and regulations governing reciprocity with other states; and administration of the State Board examinations, which are given twice a year.

Until May, 1947, the State Board examinations were prepared and evaluated by members of the Board. In May, 1947, standardized tests were first used in Indiana. These tests, now used by two territories and more than 32 states, are prepared under the direction of the Department of Measurement of the National League of Nursing Education and are designed to test the students' ability to apply their knowledge of the subjects to nursing situations rather than to test factual materials. The answer sheets are returned to the National League of Nursing Education, where they are machine scored. This method affords an opportunity to compare the scores made by the nurses of Indiana with those made by nurses in other states, gives the schools of nursing in Indiana the opportunity of defining weaknesses in the program as evidenced by the scores made by their students on the tests, and provides a testing program with a higher degree of validity and reliability. After passing the examinations, the nurse registers with a county clerk and thereby becomes a Registered Nurse.

A full-time educational director is employed by the Board. Miss Mary T. Walsh served in this capacity from 1931 to 1946, when she retired. Miss Caroline Hauenstein, the present educational director, was appointed at that time.

Conclusions

During the crucial years of development, the nurses of Indiana have faced and solved many perplexing problems. They have worked together to accomplish those things which seemed best for the public, for the profession, and for the individual nurse. Many have taken a place among the national nursing leaders of their period. The growth of nursing in Indiana has kept stride with the progress made in the related fields of education, science, medicine, surgery, and public health. Hence we have reason to believe that, having become firmly established, nursing stands now at the threshold of a period of great promise, in which it will make even greater contributions to society in the years ahead.

⁶ *Laws of the State of Indiana Concerning the State Board of Examination and Registration of Nurses.*

XIII

HISTORY OF MEDICAL SOCIAL SERVICE IN INDIANA

ROBERT E. NEFF*

IN THE first decade of the twentieth century medical social service was beginning to reach a status which commanded the attention of medical authorities. In wide-spread areas recognition was developing toward a common connection between sickness and poverty as being more than a mere coincidence. Full consideration was given to the elements lying outside the limitations of conventional medical practice which were basic to an understanding of a patient's financial status, family life, and general intelligence; whether there was sufficient search for causes of diseases more remote than those found under the microscope or in the physical examination; in short, whether the patient was being merely treated, or the disease or condition attacked by going to the root of the patient's trouble. The fundamental problems involved in the patient's social environment had to be attacked in the treatment of the patient. Physicians and social workers have always been in need of mutual help and understanding, and there was recognition that they should plan and execute their work together if the patient was to receive the most intelligent care. Social adjustments were considered as important and closely related to illness of the individual, needing more attention than the casual perceptions of the medical practitioner.

The medical social worker was becoming a component part of organized medicine because of her skill in understanding social problems and her equipment by training and experience to help guide the patient in solving those personal problems that may arise from his illness or to which his illness may have been due in part, or whole. It was demonstrated that the medical social worker could make a place for herself in medicine because of her ability to study and understand social distress as it relates to physical disease. The social worker was a co-worker of the physician and could assist in the solution of many medical problems by virtue of her ability to remove handicaps to successful treatment by the physician. Occupational etiologic conditions uncovered by the social worker were found to be important factors in the illness of certain patients, and there was a question of profit in curing the patient medically but permitting him to return to his old environment or occupation where his illness would again develop.

This development in medical social service attracted the attention of U. G. Weatherly, Professor of Sociology at Indiana University in 1911. In June of that year Dr. Weatherly had been successful in securing an appropriation of \$800.00 from the Board of Trustees for social work in connection with Indiana University School of Medicine

and Dispensary, at Indianapolis. Dr. Weatherly foresaw an excellent opportunity for laboratory work for his students in Sociology by the use of these facilities in Indianapolis.

In September of 1911 medical social service was actually begun at the Indianapolis City Dispensary and the Indiana University School of Medicine, as an organization connected with the Department of Sociology of Indiana University. Miss Edna G. Henry was employed as the first worker in the department.

The objectives of the department as expressed at that time were:

1. To further the cure of Indianapolis Dispensary patients.
2. To secure statistics concerning these patients—statistics which would form the basis of social research.

During the first year the department dealt with patients referred to it by the physicians at the City Dispensary. So, it may be noted that social service work as it began at the Indiana University was medical social service.

In June, 1911, the Board of Trustees of Indiana University authorized the appointment of Dr. Charles P. Emerson as dean of the Indiana University School of Medicine. Dr. Emerson assumed the deanship that year. Dr. Emerson had studied in the Universities of Strausburg and Basil, and in Paris; he had served as resident and associate in Medicine at Johns Hopkins Medical School and had been superintendent of Clifton Springs (New York) Sanatorium. He had served as an associate professor of Medicine at Cornell University of Medicine. While at Johns Hopkins Medical School Doctor Emerson became interested in medical social service. He considered that in certain illnesses a change of occupation with the accompanying social readjustment was part of the necessary therapy in the treatment of patients. When he took up his duties at Indiana University he was pleased to find that medical social service work had already been started in a simple way in connection with the Medical School and Dispensary, and he joined heartily in its promotion.

Doctor Emerson claimed that the social service movement was a remarkable as well as a most important and promising improvement in modern medicine. In his 1912 report to Governor James P. Goodrich he stated that 75 hospitals and dispensaries in the United States were equipped with Medical Social Service Departments, and indicated that the origin followed a recognition of these facts:

* Superintendent. Methodist Hospital, Indianapolis.

1. Many poor patients need change in the matter of working and living conditions more than they need medicines;
2. Many poor persons cannot, without assistance, follow the advice given them by their doctors; and
3. That among many patients a little social service, while the physical troubles are slight, is likely to prevent the development of far worse conditions than those then present.

During the latter part of the year 1912 the beginning of a more formal organization of the Medical Social Service Department was made with Miss Edna G. Henry being given the title of Director of the Department. During that year Miss Mabel Newton was appointed her assistant. Miss Henry, in one of her early reports to President William Lowe Bryan and the Board of Trustees of Indiana University, set forth the fact that medical social service falls into three distinct classes:

A. EDUCATION :

1. The instruction of medical students in social problems began at this time with the one hour a week lecture by Doctor Emerson on patients of the department. The visiting of patients by medical student volunteers was also instituted with the result that 59 medical students volunteered their services for following Dispensary patients by visiting their homes and making first hand investigation of their social problems. This volunteer service provided a better follow-up service for Dispensary patients and gave students a better knowledge of medicine as it related to economic and social conditions. It was emphasized that the student was enabled to learn how to deal with patients and become a family physician, as well as to see more clearly the moral values and the truths of human nature. It was further emphasized that this program enabled the University to provide instruction which would make the medical student not only a better doctor but a true apostle of hygiene and preventive medicine.
2. Instruction of Sociology students from the University in economic problems involving disease was supplemented and strengthened by the facilities in the Social Service Department. Opportunity to combine practice with theory was made possible. Instruction given by Dr. U. G. Weatherly of Bloomington, supplemented by the use of first-hand knowledge with the practical work done in the department at Indianapolis gave further development to the educational phases of the program.
3. The program emphasized the education of the patient, and also the education of the public. The education of the public was considered a most important phase of the work of the Social Service Department, it being indicated that the public must learn the reasons for and the economic value of personal responsibility, preventive medicine, State Hospitals and the cure of patients in institutions.

During all this time much was accomplished along these lines through the weekly lectures and clinics at the Indiana University School of Medicine, conducted by Dean Emerson. These included a series of lectures open to welfare workers, civic

minded individuals particularly members of the Women's Department Club. Doctor Emerson also made many talks throughout the state on the subject.

B. RESEARCH :

1. A record system established by Miss Henry afforded an accumulation of much information concerning dependent patients and the tabulation of statistics drawn from the records of the department in the early years of its operation; soon presented important information for the teaching of medical and Sociology students. Two graduate students, Dorothy Ketcham and Donna Thompson, were among the earliest students to receive credit towards the Master of Arts degree. The records of the department in May, 1933, showed that 943 patients and their families were listed as patients at that time. It was reported that the work which the Department had done during the great flood of March 1913 when 6,318 families had been visited had furnished much valuable teaching information. The department undertook this survey of the flood district at the request of the Indianapolis City Board of Health, headed by T. Victor Keene, and for eight weeks carried on this survey involving the supervision of nurses, volunteer workers, stenographers and medical students.

C. CARE OF PATIENTS :

1. In 1912 Miss Henry's report to the Board of Trustees indicated that the department had dealt with 796 patients that year and that these patients were referred by 48 different physicians from 13 clinics in the Indianapolis City Dispensary, for 96 different reasons.
2. Emphasis was placed upon the ability to offer encouragement to patients; through cooperation with other social agencies and socially minded individuals transportation was provided to patients for trips to and from the Dispensary; braces, spectacles, elastic stockings and other appliances as prescribed by physicians were made available for patients; lodging was provided for needy cases; patients were directed in a change of habits which might handicap treatment; improper feeding of children was given attention; relief and special funds necessary in individual cases were not overlooked; institutional care was arranged and the care of unmarried mothers and home visiting was looked after as individual cases were presented by physicians where such services could help solve the medical problems of patients concerned.

Some of the more common causes for referring patients to the department were: venereal disease, tuberculosis, mental and nervous diseases, improperly fed children, patients requiring temporary or permanent relief, those requiring nursing care at home, drink and drug habitues, lack of employment or the necessity for change in employment on account of certain occupational disease factors. Those patients and families who were found to need financial assistance in order to help solve their social problems in connection with their medical treatment were cared for from the outside and not by the department. Volunteer contributions by various organizations, including church groups, and by individuals interested by Miss Henry in the work of her department made this financial assistance possible.

In June, 1914, the Robert W. Long Hospital was opened and it was recognized that there should be an agent of the department in that institution in addition to the service then operated at the City Dispensary. A field worker to travel throughout the state was recommended by Miss Henry for help in the selection of state patients for the hospital, to arrange in their own communities for their after care, as well as to spread further knowledge concerning preventable and curable diseases. At this time the department had developed to a point where additional personnel were added to Miss Henry's staff, including two clerical and stenographic workers and Miss Belle Emden, a visiting nurse, the latter being financed by the Women's Department Club of Indianapolis to the extent of about \$900.00 per year. Miss Emden's services were directed principally toward the City Dispensary Obstetrical Program which at that time was inaugurating pre-natal care service among its patients. In November, 1914, social service was given the status of a department of Indiana University with Miss Henry as the director and a member of the faculty of the University.

Miss Henry conducted a broad and intensive campaign among the various civic organizations and interested individuals in Indianapolis, with the result that considerable interest was enlisted in the work. She emphasized to these groups the fact that in the interest of a broad consideration of the conservation of human forces, to say nothing of the economy, Indiana should take active measures to control illness and disease. She declared that it was no exaggeration to say that a well-trained social worker for each dollar expended would save the state of Indiana at least several hundred dollars in the future institutional care of incurable patients and their hopeless offsprings.

In 1915 we find that a state worker was employed to visit the various communities in the state of Indiana from which patients had been sent to the Long Hospital where the furtherance of the cure and care of the patient was carried out. She was charged with the discovery and the creation of resources in these communities for future use of the department. Miss Edith Spray was given the appointment as the first state worker. The state worker did not overlook the opportunity presented by her visits to these communities in educating the public concerning the problems of poverty and sickness. During the period September, 1915 to May, 1916, the state worker visited 40 towns.

In August, 1915, the department was moved to the Robert W. Long Hospital. The records of the department indicate that during the period June 14, 1914 (the opening date of the hospital) to April 1, 1916, 1,109 of the 1,353 free and part pay patients treated at the Robert W. Long Hospital had been brought to the attention of the Social Service Department for investigation and follow-up in connection with their treatment as hospital patients. The records report a specific case of follow-up care

by the Hospital state worker where one trip into the patient's home county cost \$8.00 for travel expense and saved four months' hospital care of a child.

In May, 1916, Miss Henry's report indicates "there was no county in which the department lacked acquaintance with people who would attempt to accept the burden imposed by the department's demand that each locality should care for its own patients" in matters pertaining to treatment responsibilities necessary to supplement the care received at the Robert W. Long Hospital.

In the fall of 1915, after the department had moved to the Robert W. Long Hospital, the University transferred its financial support entirely to the work of the department at the Long Hospital. The work in the City Dispensary was continued under the direction of Miss Henry and financed by a committee of Indianapolis women who served as an Advisory Committee and later became known as the Dispensary Aid. The Dispensary Aid rendered very signal service, not only through the financial aid which they were able to provide but as a liaison between the Dispensary service and interested groups and individuals in Indianapolis.

Miss Henry continued as director of the department until 1921 when, because of failing health, her responsibilities as director were passed on to Mr. Robert E. Neff, the administrator of the Indiana University Hospitals. Miss Henry continued to carry the educational responsibilities of the department with the rank of associate professor. In the year 1926 the name of Miss Henry as an associate professor was omitted from the Social Service staff because of illness. She was bed-ridden and for a time carried on some of her classes in her home, but this had been given up.

Mr. Neff, on account of added pressure of his administrative duties when the Riley Hospital opened in October, 1924, was relieved as director and that directorship was placed in the hands of Dr. U. G. Weatherly and Dean Charles P. Emerson, with authority to select an assistant director. Dean Emerson's part of this work was scheduled in the *Medical Bulletin* at the time as "Medical Sociology and Environment Medicine," while Dr. Weatherly assumed charge of the general aspect of Sociology.

In the year 1924 a change in the emphasis was introduced. A course of study extending through four years was announced in the department of Sociology, Indiana University, in which the work of the first three years was largely prescribed and given at Bloomington, and students were sent to Indianapolis for the fourth year of this course of study leading to a baccalaureate degree. In 1927 Associate Professor Clyde White joined the staff in Indianapolis, at which time the non-medical aspect of social service was further emphasized. Professor White became the director of the Bu-

reau of Social Research in 1930 in connection with the Extension Division of the University and continued in that position until the close of the year 1935-6.

With the passing of Dean Emerson from leadership at the Indiana University School of Medicine in July, 1931, medical social service did not long survive at the Medical School and Hospitals, however the *Medical Bulletin* published in June, 1932, recorded the fact that social service work for 1931-2 was carried on in charge of Dr. T. B. Rice, as acting director. The following year medical social service was dropped from the *Medical Bulletin*, however the teaching of social service at Indianapolis was continued under the direction of Professor Weatherly as a course in the Department of Sociology in the graduate school until July, 1935, when Professor U. G. Weatherly was retired and was succeeded by Professor Edwin H. Sutherlin in 1944. Training courses for social work in Indianapolis were given a special heading in the announcements with Professor Sutherlin as director of the Training Course for Social Work in Indianapolis. Professor Sutherlin continued in this capacity until February, 1945, at which time Miss Grace Browning became professor of Social Work and director of the Division of Social Service, which division was given departmental status in the College of Arts and Sciences and in the graduate school of Indiana University.

With the enlargement of the Medical Center and the increased emphasis on case work teaching through the Extension Division of the University, the case work responsibilities of the Medical Social Service Department at the Indiana University Medical Center were curtailed, leaving a service devoted principally to the investigation of financial resources of the patients. From 1931 to 1947 therefore medical social service was practically non-existent at the Medical Center, with the exception of special case work in a few individual clinics. Fortunately this interruption of social service was not permanent, and in October, 1947, through the cooperation of the Graduate School of Social Service of Indiana University (located in Indianapolis) and the Medical School, the Medical Social Service Department at the Medical Center was reactivated, and two trained social workers were appointed to reorganize the work. Cases are referred to this department from all the hospitals included in the Medical Center, by doctors, nurses and other interested social agencies. Some home visits are being made in special follow-up cases, but the staff so far has not enough workers to include field work to any great extent, and cooperation with other agencies (especially in out of town cases) is the

usual means of supervision after discharge from the hospital.

This department will cooperate with the hospital medical staff by investigation of social backgrounds which might be contributing factors in medical problems, and in readjustment of patients to home environment after discharge from hospital, where special continued treatment or rehabilitation is indicated.

Graduate social service students of Indiana University will be given training in medical social case work under careful supervision of the hospital social service staff.

Medical social service had its beginning at the Indianapolis City Hospital in 1918, when Dr. W. D. Gatch, at the time chairman of the city Board of Health, suggested the establishment of a medical Social Service Department at the hospital. Two rooms were assigned for offices, and Mrs. Ruth Miller was appointed as the first social worker in the hospital. For the first four years she had only one assistant, but in 1922 the staff was increased to five workers.

Despite some early antagonism from the hospital staff, Mrs. Miller gradually won their cooperation. As part of the social work program financial investigations of patients were instituted, and an attempt was made to screen patients who were able to pay for private medical care. This project incurred much public criticism through the newspapers, but gradually the public became educated to the actual welfare accomplished by the Social Service Department as a whole and so it survived in spite of criticism.

By 1940 the department had expanded to a staff of twelve workers, plus three extra workers who were assigned exclusively to the financial investigation work in the admitting department of the hospital, but who were supervised by the director of the Social Service Department. The recommendations for rejection of patients on the basis of financial ability to pay medical expenses must be approved by the Social Service Department before being accepted by the hospital business administration.

The Social Service Department has operated in much the same way since its reorganization in 1940. Patients are referred from the out-patient clinics, hospital wards and outside social agencies. Social adjustments in homes or institutional environments are arranged after hospital discharge in cooperation with the medical directions from the hospital staff. After thirty years of service to the community there is now no doubt as to the value of the Social Service Department in the Indianapolis City Hospital, now known as the Indianapolis General Hospital.

XIV

HOOSIER PHARMACY: AN HISTORICAL SKETCH

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PHARMACY is the art and science of preparing, from natural and synthetic sources, suitable materials for use as drugs. It includes the compounding and dispensing of drugs and medicines, as ordered by physicians on prescriptions, and their distribution in other ways. Pharmacy also embraces the collection, identification, preservation, manufacture, analysis, and standardization of drugs and medicines, and the preparation, standardization, and storage of biological products.

Throughout the years medicine and pharmacy have made genuine progress in the prevention and cure of disease. The part that pharmacy has played cannot be set forth in detail in this chapter; the authors are cognizant of the incompleteness of this sketch concerning pharmacy in Indiana for the century past, and they hope that sometime in the future a history of each of the acknowledged fields of the profession will be written in more detail. However, an endeavor has been made herein to depict some of the developments in practice, education, and organization that have contributed to the advancements of the professions.

THE PRACTICE OF PHARMACY

Retail

The most conspicuous manifestation of the practice of pharmacy lies in the retail drug store. The many ramifications of the profession have their roots in the retail practice. The leading men in the field have usually begun as practicing pharmacists, and most of the best known wholesale and industrial firms grew out of retail stores. Many of the early pharmacies in Indiana were founded by physicians who dispensed medications in conjunction with their medical practices. Later, when the duties of their practices became more pressing, these doctors hired pharmacists to operate the stores. In many instances the pharmacists later bought the stores, thus benefiting both from an established clientele and from the business relationship with the physician.

Fort Wayne, which originated about 1600 as a village of Miami Indians, is probably the oldest city in the state. Even dating the city from 1794, when the original fort was built by Mad Anthony Wayne, it ranks among Indiana's first. It is interesting to note that in 1865, Joseph C. Hoagland, then a druggist in Fort Wayne, compounded a group of chemicals which resulted in the widely used product, baking powder. Thus began the manufacture of Royal Baking Powder. Mr. Hoag-

land later moved to New York where he began large scale manufacture of his product. Interesting also is a newspaper item, dated 1876, which reads, "Dr. Meyers sent a prescription *by telephone* from the city hospital to Meyer Bros. Drug Store and it was promptly filled."¹

The stores owned by Frank Hubbard of Auburn and Melvin Kratz of Angola are typical of the early pharmacies of northeastern Indiana. Some of the early prescriptions in the Hubbard store (1885) were written in German and date back to the early days when a large portion of the doctors and druggists of the community were of German birth. The store at Angola was in operation before 1868, but its origins are not known.²

Two of the oldest drug stores in the northwestern section of the state are to be found still in operation in South Bend. The Hans Pharmacy (1870) and the Reliance Pharmacy (1900) are closely related historically since they both were established by Mr. Leo Eliel, one of Indiana's well known pharmacists.³

In Lafayette, there were three stores flourishing before the Civil War. In the history of the Wells-Yeager-Best store, which dates beyond 1835, there figure two doctors; a Doctor Farmer, who sold the store in 1837, and Dr. A. A. Wells, who purchased it in 1881 and whose name it still carries. The year 1842 marked the beginning of two stores there which later came under the ownership of the Hogan brothers; another old store operating since at least the time of the Civil War is the Schnaible Drug Company. It is reported that Colonel Eli Lilly served his apprenticeship in the Good Samaritan Drug Store, one of the Hogan stores then owned by Mr. Henry Lawrence, and worked in the Schnaible store during his early years.⁴

Four drug stores in the town of Greensburg, "operating under the shade of the tree growing out of the courthouse tower," rank among the oldest pharmacies in Indiana. The present St. John and Guthrie Drug Store and the T. C. Wright Drug Store were both started about 1832; the former was once (1840) owned by Daniel Stewart, later of the house of Kiefer-Stewart. F. M. Henry and Company (1900) and the Batterton Drug Store (1854) are other members of the foursome.⁵ Typical of the very old professional stores in the southeastern part of the state is the Carpenter Drug Store in Columbus, which is the ethical store it has been

(1) *The Indiana Pharmacist*, n.s., 20, 231 (1933).

(2) *Ibid*, 270.

(3) *The Indiana Pharmacist*, n.s., 21, 6 (1933).

(4) *Ibid*, 36.

(5) *Ibid*, 116.

(6) *Ibid*, 148.

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since it was established about 1860.⁶ Among others in this section are: Harper and Company (1845), the Rogers Drug Store (1853), and the Wetzel Drug Store (1874), all of Madison; the Willett Drug Store (1859), Corydon; McClintock's Drug Store (1869), Salem; the Spencer Drug Store (1858), Versailles; the Parke Drug Store (1878), Scottsburg; the Ullrich Drug Store (before 1886), Aurora; Dillsboro Drug Store (1889); and the Nauer Drug Store (early 1860's), Vernon.⁷

Terre Haute can boast of one of the early industrial houses in Buntin and Armstrong, which began in—and later returned to its business as—a retail store. Contemporary with that firm was the Baur Pharmacy, opened in 1866, which became one of the leading prescription shops in Terre Haute.⁸ In the southwestern section of Indiana we find an example of a very old drug store in the one operated for many years by Mr. Taylor C. Basye. The store was founded in 1858 by Dr. Oliver Morgan and was sold to Mr. Basye's father in 1862. Mr. Basye was born the same year and has been heard to remark, "I started in the drug business the next day."⁹ The Schreiber store in Tell City (1865) and the Rothrock store in Mount Vernon (1880's),¹⁰ the F. M. Petersheim store (1883), the W. E. Fritsch store (1866), and the F. A. Illing store (1873) in Evansville are of special historical interest.¹¹

Of more recent origin is the first strictly prescription shop in Indianapolis, that established about the year 1879 by John N. Hurty, later Dr. John N. Hurty, who became renowned as the secretary of the Indiana State Board of Health. This store, then as well known as its famous proprietor, has its current counterparts in other prescription pharmacies now operating in Indianapolis: the Stokes Pharmacy (1920) and the Brookshire Pharmacy (1924).¹²

This list of early Indiana retail drug stores is, at best, exemplary; it is by no means complete. Age is an indication of service, but it is not the only criterion by which to judge a good shop. Retail businesses pass from proprietor to proprietor, names are changed, records are lost, and new stores are opened; policies vary with management. It must be remembered, however, that it is in the retail drug store where the profession of pharmacy best meets those whom it serves: the physicians and the people.

Wholesale

Kiefer-Stewart Company. Daniel Stewart and his father, Silas, took over a retail business at Greensburg in 1840, the year in which B. Hammerman and Company set up business as wholesale druggists in Indianapolis. In 1863, Daniel Stewart

bought the Hammerman Company and operated it under the names of Stewart and Morgan (1863-1876), Stewart and Barry (1876-1883), and Daniel Stewart Company. The same year in which Daniel Stewart came to Indianapolis, Augustus Kiefer sold his interest in a retail store in Edinburg to organize the Dailey, Kiefer, and Rush Wholesale Drug Company in Indianapolis. In 1866, this firm's name was changed to Kiefer and Vinton, and in 1872, to A. Kiefer and Company. It was in 1876 that the first order of the Eli Lilly Company was delivered to the A. Kiefer and Company by the late J. K. Lilly, then fourteen years old, and on the occasion of the fiftieth anniversary of Eli Lilly and Company in 1926, A. Kiefer Meyer, grandson of Augustus Kiefer, delivered to Mr. Eli Lilly, grandson of Col. Eli Lilly, a basket of orders amounting to \$50,000.00.¹³ In 1915, the Daniel Stewart Company and the A. Kiefer Drug Company were merged to form the Kiefer-Stewart Company. Three additional merchandising firms are now owned or controlled by the Company constituting one of the largest and strongest wholesale drug houses in the nation.^{13, 14}

Mooney-Mueller-Ward Company. Two physicians were instrumental in the founding of the Mooney-Mueller-Ward Company: Ward Brothers Drug Company was founded in the early 1870's by Marion Ward and Dr. Boswell Ward; J. George Mueller established the Indianapolis Drug Company in 1890, forming a partnership with John Miller and Dr. Herman Pink, a local family physician. The latter concern joined forces with William J. Mooney in 1902 and formed the corporation of Mooney-Mueller Drug Company, which, in 1915, when the merger with Ward Brothers Drug Company took place, became the Mooney-Mueller-Ward Company. This firm serves the retail druggists throughout the city of Indianapolis and the state of Indiana.^{15, 16, 17}

In addition to the two well known Indianapolis wholesale concerns, there are others which operate in various districts of the state: The Chas. Leich and Company (1854), Evansville¹⁸; E. H. Bindley and Company (1862), Terre Haute¹⁹; the Fort Wayne Drug Company (1899)²⁰; and the South Bend Wholesale Drug Company (1913)²¹.

Although the wholesale businesses aim to fill the needs of the pharmacist in the store, by so doing, they also serve the physicians, in that they furnish to the retail pharmacist those items which are prescribed by the practicing physician. They

(7) *Ibid.*, 152.

(8) *The Indiana Pharmacist*, n.s., 20, 301 (1938).

(9) *Ibid.*, 233.

(10) *Ibid.*, 238.

(11) *Ibid.*, 239.

(12) *The Indiana Pharmacist*, n.s., 21, 71 (1939).

(13) Personal correspondence with G. Barret Moxley, 1947.

(14) *The Indiana Pharmacist*, n.s., 21, 84 (1939).

(15) Personal correspondence with Wm. J. Mooney, January 13, 1948.

(16) Personal correspondence with Clemens O. Mueller, February 4, 1948.

(17) *The Indiana Pharmacist*, n.s., 21, 82 (1939).

(18) *The Indiana Pharmacist*, n.s., 20, 242 (1938).

(19) *Ibid.*, 272.

(20) *Ibid.*, 304.

(21) *The Indiana Pharmacist*, n.s., 21, 10 (1939).

act further for the pharmacist by making available from one source, drugstore items from hundreds of sources; and they are for the manufacturing pharmacists, distributors for their produce.

Industrial

One of the greatest influences of Indiana pharmacy on the medical profession has been the development of the several manufactories of the state. The preparation of pharmaceutical items on a commercial scale places at the disposal of the physician and the pharmacist the best in medication at costs the public can afford to pay. The history of industrial pharmacy in the state of Indiana dates from the close of the Civil War.

Lilly and Phelan. At the close of the war, in 1865, James Edward Lilly, a younger brother of Eli Lilly, while in the employ of Cloud, Aiken and Company, wholesale druggists of Evansville, started a laboratory for manufacturing pharmaceuticals. The extensive river trade out of the town led James, in 1870, to withdraw from the wholesale house and establish a laboratory in Evansville under the name of James E. Lilly and Company, to take advantage of the convenient and cheap transportation available. He operated the laboratory for a time as an individual enterprise; but later (1873) he took into partnership a Mr. James Phelan, and the firm became Lilly and Phelan. Despite the fact that the small concern was prosperous, it discontinued business about 1875, and Mr. Lilly took service with William R. Warner and Company of Philadelphia, until he came to Indianapolis with his brother, Eli, in 1878. The Lilly and Phelan line was notable for offering the first liquid preparation of pepsin to be placed on the American market.²²

Buntin and Armstrong. At about this same time William C. Buntin and William H. Armstrong established a laboratory in connection with the retail store they operated in Terre Haute. A flourishing business was carried on in that section of Indiana and Illinois, until the partnership was dissolved. Mr. Buntin retained ownership of the drug store, but soon after the separation, he abandoned the manufacturing department; Mr. Armstrong went to Indianapolis where he established the Armstrong Surgical Supply House.²³

Johnston and Lilly. In 1873, a three-year partnership arrangement was entered into between Dr. John F. Johnston, an Indianapolis dentist, and Col. Eli Lilly, who at that time was practicing retail pharmacy in Paris, Illinois. The partnership, operating as Johnston and Lilly, although fairly successful during its term, was not renewed. The business continued for several years, however, as the John F. Johnston Company under the direction of Dr. Johnston.²³

Eli Lilly and Company. In May, 1876, Eli Lilly established a laboratory of his own. He was joined two years later by his brother James, and two years after that, in 1881, the concern was incorporated as Eli Lilly and Company, a name destined to become world famous. The firm, one of the largest and most widely known pharmaceutical houses in the world, occupies numerous properties in the city of Indianapolis; in addition, it maintains extensive biological laboratories and branch plants and offices. The fourth employee of the company was the late Josiah K. Lilly, son of the founder, who entered the business as a fourteen-year-old schoolboy in 1876.²⁴ He was very active in early Indiana pharmacy and supported enthusiastically the movements to better the profession, among other things, assisting in the organization of the Indiana Pharmaceutical Association, and contributing several items to *The Indiana Pharmacist*. He became president of the Lilly Company in 1898, and during his thirty-five years in that position, he was largely responsible for the tremendous growth and advancements made by the firm. Lilly products include full lines of fine quality pharmaceuticals, gland products, biologicals, and antibiotics.

McCoy-Howe Company. It is unfortunate that authentic records of one of the earlier substantial houses are not available; however, it was probably during the decade 1880-1890 that the McCoy-Howe Company was organized. This house did a large and profitable business in the central states, dealing directly with dispensing physicians. The management changed hands several times until the firm ceased operations and was liquidated in 1922.²³

Miles Laboratories, Inc. Dr. Franklin Miles, a pioneer nerve specialist, set up in 1884, a small business in Elkhart, called the Dr. Miles Medical Company. His purpose was to promote certain medicines he had used successfully in private practice. In 1885, a corporation was formed by Doctor Miles, Hugh McLachlan, Norris E. Felt. Over the years, the company's name was changed from Dr. Miles Medical Company to Dr. Miles Laboratories, and finally to Miles Laboratories, Inc. In 1937, the corporation organized the Effervescent Products, Inc., later the Ames Company, which handles a line of buffered effervescent drugs such as sulfa products and also diagnostic tablets. Two more companies have been purchased and absorbed into this growing institution.²⁵

Pitman-Moore Company. In Indianapolis, on July 1, 1899, Harry C. Pitman and John C. Meyers organized a manufacturing house under the corporate name of Pitman-Meyers. Twelve years later, with Mr. Harry C. Moore as president, it was reorganized as Pitman-Moore Company.

(22) Personal correspondence with John S. Wright, February 12, 1948.

(23) *The Indiana Pharmacist*, n.s., 13, No. 6, 22 (1931).

(24) *The Lilly Review*, 8, No. 2, 9 (1948).

(25) Personal correspondence with C. S. Beardsley, December 29, 1947.

This company has expanded its holdings of city property, enlarged its buildings, and has also set up large, well-equipped, biological laboratories at Zionsville. In addition to supplying physicians and pharmacists with a general line of human medications, Pitman-Moore makes available to graduate veterinarians a complete line of animal remedies. This house is associated with others of similar business interests as a division of Allied Laboratories, Inc., who are noted as the world's largest producers of biological serums.²⁶

Swan-Meyers Company. Founded February 1, 1909, by John C. Meyers, Rolly M. Cain and Joseph C. Swan, the Swan-Meyers Company of Indianapolis maintained a comprehensive line of pharmaceuticals and specialties for twenty years. It was with regret that the members of the medical professions in Indiana viewed the removal of that firm's business from the state, when it merged with Abbott Laboratories in the fall of 1929.²³

Mead, Johnson and Company. Of a somewhat different character is the corporation of Mead, Johnson and Company of Evansville, organized in the state of New Jersey in 1900, but moved to Evansville in the fall of 1915. It has been very successful in the scientific production of infant foods and other valuable dietary and vitamin products, which are made available to the medical professions along ethical lines.²³

Operating in our state at the present time are also: the Central Pharmacal Company, Seymour (1904); the Lafayette Pharmacal, Inc. (1906), currently manufacturing diagnostic opaques; the C. B. Kendall Laboratories, Indianapolis; Chemico Laboratories, Indianapolis; the Underwood Chemical Company, Indianapolis;²² and the C. M. Bundy Company (1913), which conducts a large business supplying pharmaceuticals in bulk to those who desire to repackage under their own labels.²³

It is evident that the state of Indiana enjoys a very generous portion of the pharmaceutical manufacturing business of the country. The benefits of such centralization to the members of the several medical professions cannot be overestimated. Besides supporting extensive research laboratories of their own, these firms contribute substantially to the research programs of the professional schools and universities. They assume the responsibility of developing new remedial agents and translating the results of research into valuable products for the prevention and treatment of disease. They also maintain a system of education through the men who represent them; these "detail" men of the pharmaceutical manufacturers, who disseminate the latest information about new products and new uses for old ones, are indispensable to the busy physician and pharmacist.

PHARMACEUTICAL EDUCATION

In the days of the "apprenticeship" method of instruction, education of the young pharmacist began and usually ended in the drug store. The apprentice of a good pharmacist was very fortunate, but some druggists were reluctant to divulge their knowledge of the profession to a possible future competitor. The opportunities for college training were small. As early as 1873, Fort Wayne College, under the patronage of the Methodist Episcopal Church, issued a circular announcing that "instruction in pharmacy will be given by Mr. H. V. Sweringen." The circular did not state, however, to what extent and in what manner pharmacy was to be taught, but it was considered that the course was probably preparatory for entering a college of pharmacy.²⁷

Purdue University. The trustees of Purdue University established a department of pharmacy in 1884, in response to an earnest and growing demand for a thorough and practical training in pharmacy and pharmaceutical chemistry. Previously there had been established in other states several schools of pharmacy of considerable reputation, and the growing desire for such a school among the druggists of Indiana was natural. To Dr. John N. Hurty, an eminent pharmacist and physician of Indianapolis, credit is due for bringing to the attention of Dr. James H. Smart, then president of Purdue University, the desire and need for such a school. In addition to being a progressive druggist Doctor Hurty had an enviable reputation at that time as a chemist and toxicologist.

On one occasion (1883), Doctor Hurty asked President Smart why the university did not have a department of pharmacy. Without hesitation Dr. Smart replied, "I am for it good and strong and will present the matter to the next board meeting, providing you will act as professor of pharmacy for at least two years."²⁸ This promise was obtained, and the matter was presented to the Board of Trustees of the university who acted favorably and the School of Pharmacy was permanently established.

The authorities of the university endeavored to combine the advantages of all the other schools of pharmacy; they required, therefore, a considerable amount of experience for admission and a still larger amount of college work than was theretofore usually offered in other institutions. It was expected thus to maintain a school of a high degree of excellence which would secure the goodwill not only of the pharmacists but also of the people of the state. With this object in mind, the first courses included junior and senior curricula of twenty weeks of instruction each.²⁹ The

(27) *American Journal of Pharmacy*, 45, 429 (1873).

(28) Unpublished manuscript by Dr. George Spitzer.

(29) *The Tenth Annual Register of Purdue University*, 81-91 (1883-1884).

(26) Personal correspondence with C. N. Angst, February 11, 1948.

first faculty of the School of Pharmacy consisted of:

James H. Smart, A.M., LL.D., President of the University;

Robert B. Warder, A.M., B.S., Professor of Chemistry;

John N. Hurty, M.D., Professor of Pharmacy;

Alembert W. Brayton, M.S., M.D., Professor of Materia Medica and Toxicology;

Charles R. Barnes, A.M., Professor of Botany.

Both Doctor Hurty and Doctor Brayton were from Indianapolis; each arranged to spend one day a week on the campus at Lafayette. They came to the university with the rank of professor, and Doctor Hurty was, in addition, dean. The other members of the faculty, although not particularly interested in pharmacy, were enthusiastic in their support of the new enterprise.³⁰

In 1884, the first catalogue of the school was issued, and there were in the School of Pharmacy during the first year (1884-1885) seven students enrolled as juniors. The first graduating class (1886) consisted also of seven members; however, not all of them were of the original seven junior students.^{31, 32}

During the first year of the existence of the school, practical experience in a dispensing pharmacy, in addition to the prescribed work, was required for graduation; to students with such experience the degree of Graduate in Pharmacy (Ph.G.) was given. Over the course of several years, the curriculum was increased and expanded. Two curricula were added in addition to the one leading to the Ph.G. degree, a three-year and a four-year course, leading to the degrees of Pharmaceutical Chemist and Bachelor of Science in Pharmacy, respectively. These expansions exemplify the trends in pharmaceutical education, by both schools of pharmacy and boards of pharmacy, to elevate the profession to a status of importance equal to other professions. The Purdue University School of Pharmacy has been in a position of leadership in pharmaceutical education throughout the sixty-four years of its existence.

The school today is one of the leading schools of pharmacy in the country. It is recognized by both the American Association of Colleges of Pharmacy and the American Council on Pharmaceutical Education. In addition to the Bachelor of Science degree, offered for not less than four years' work, programs are set up for additional study towards the degrees of Master of Science and Doctor of Philosophy in the areas of pharmacy, pharmaceutical chemistry, pharmacognosy, and pharmacology.³³

Valparaiso University. The Department of Pharmacy of the Normal School and Business

Institute of Valparaiso was organized in the fall of 1892 with the first class of sixteen students graduating in the summer of 1893. Professor A. E. Hiss was placed in charge of the department. The first course was of fifty weeks' duration with no vacation periods and, since no outside work was permitted on the part of the student, the course was a complete fifty-week period. Practically no previous education was required for entrance into this course of instruction. The list of required courses as given in the early catalogues shows an ambitious attempt to offer a very thorough course in the short time allotted.

In 1906, when the institution was incorporated as Valparaiso University, the Department of Pharmacy began to offer a two-year course of 72 weeks and a three-year course of 108 weeks, the graduates of which were respectively given the degrees of Graduate in Pharmacy (Ph.G.) and Pharmaceutical Chemist (Ph.C.). A one year post-graduate course of 36 weeks was also offered to graduates of other pharmacy schools. The entrance requirement for the undergraduate courses was a minimum of two years' attendance in high school. After 1915, full graduation from a four-year course in high school was required. In 1916, the Department of Pharmacy became the School of Pharmacy, and later the name was changed to the College of Pharmacy. In 1923, the curriculum was extended to include the four-year course, leading to the degree of Bachelor of Science.

In 1938, the faculty and students were notified that the university was no longer able to meet the increasing standards for accreditation in pharmacy with the small enrollment. The decision was made to discontinue the College of Pharmacy by graduating the last class in June, 1940.³⁴

Notre Dame University. The Department of Pharmacy of Notre Dame University was organized as a unit in the College of Science in 1897; Mr. Leo Eliel, a prominent pharmacist of South Bend, was in charge. In 1898, two courses were offered, one for two years leading to the degree of Graduate in Pharmacy (Ph.G.), the other for three years leading to the degree of Pharmaceutical Chemist (Ph.C.). During the next several years, entrance requirements were raised, new courses were introduced, and in 1910, a four-year course was added to the curriculum, leading to the Bachelor of Science degree.

Although the majority of graduates of the department entered the profession in its many ramifications, many others entered allied professions of biology, medicine and chemistry. One outstanding graduate made himself and his alma mater famous in a field far removed from pharmacy. Knute K. Rockne, the well known head coach and athletic director at Notre Dame, graduated from the Department of Pharmacy there.

In August, 1936, the University Council, after careful consideration of a number of factors for several years, announced that the gradually de-

(30) Rice, Thurman B., *The Hoosier Health Officer*, n.p., 1939-1946, p. 25.

(31) *Purdue University, First Annual Announcement of the School of Pharmacy (1884-1885)*.

(32) *Purdue University, Second Annual Announcement of the School of Pharmacy (1885-1886)*.

(33) *The Indiana Pharmacist*, n.s., 13, No. 6, 24 (1931).

creasing enrollment in the department and the increased standards for accreditation could not justify the continuation of the school. The graduation of the June, 1939, class marked the discontinuance of the department.³⁵

Tri-State College. Courses in the School of Pharmacy at Tri-State College began in 1902. The College of Pharmacy was organized as a coordinate school in 1910 with C. C. Sherrard as dean. During the period of its existence, four courses were offered: (1) Forty weeks of study, leading to the Ph.G. degree; (2) Two years of 36 weeks each, leading to the Ph.C. degree; (3) Four years of 36 weeks each, leading to the degree of Bachelor of Science in Pharmacy (B.S. Ph.); and (4) A review course for those who desired to review for the state board examination. The Tri-State College of Pharmacy was discontinued in 1919.³⁶

Butler University. The Butler University College of Pharmacy was first established in April, 1904, as a department of the Winona Technical Institute, which institution had college departments of pharmacy, chemistry, electricity, and engineering. The Pharmacy Department began work in September, 1904, with twelve students, and eleven were graduated in the first class.³⁷ Prof. John A. Gertler, previously of the Department of Pharmacy at Northern Ohio University, was director. The college year at that time extended 26 weeks; two such years were required for graduation.

Although the departments of pharmacy and chemistry prospered, the other departments of the Institute failed to do so. In 1914, a new charter was procured in the name of the Indianapolis College of Pharmacy, and the original property, the United States Arsenal grounds, was sold to the city of Indianapolis for high school purposes. After being housed in temporary quarters for a time, the college was established in the buildings of the former Indiana Veterinary College on East Market Street.

The standards and aims of the college curriculum have been moved upward regularly in conformity with, and often in advance of, those required by the boards of pharmacy. The length of the college year is 36 weeks, beginning in September and ending in June. In 1923, high school graduation was made the requirement for entrance. In 1925, a minimum three-year course was the only one offered to incoming freshmen. In 1927, the college became a member of the American Association of Colleges of Pharmacy and in 1941, it was accredited by the American Council on Pharmaceutical Education.³⁸

In October, 1945, the Indianapolis College of Pharmacy was merged with Butler University,

and it became one of the six colleges of that institution. While the college is still housed in its buildings on Market Street, funds have been raised to erect a new pharmacy building on the Butler campus.³⁹

Educational progress, brought about by the leadership of the schools and boards of pharmacy, has shown considerable development from short, one-year courses to minimum, full, four-year curricula. The schools have offered, and the state boards have required, progressively more and better education. The current requirements for registration in the state of Indiana include, in addition to the Bachelor of Science degree, one year of "internship" under the direction of a registered pharmacist.

ASSOCIATION OF PHARMACISTS

Local. Reports of early local associations (those in existence before the founding of the Indiana Pharmaceutical Association) are difficult to ascertain and authenticate. That such organizations did exist is certain, since many early issues of *The Indiana Pharmacist* announced meetings of local groups or gave accounts of meetings already held. Evansville, long known for its pharmaceutical professionalism, had an active local association.⁴⁰ Others mentioned in the early journals are: Hamilton County;⁴¹ Indianapolis;⁴² Terre Haute;⁴² Clay County;⁴³ St. Joseph County;⁴⁴ Fort Wayne;⁴⁵ Tippecanoe County, known as the Lafayette Pharmaceutical Association;⁴⁶ and the Purdue Pharmaceutical Society.⁴⁷

The Indiana Pharmaceutical Association. There was, in the very early 1880's, a growing sentiment in Indiana for a state pharmaceutical association. The organization of state associations was very much in vogue; allied professional groups, the physicians, had organized (1848); local groups wanted it; the American Pharmaceutical Association members resident in the state were wholeheartedly in support of the movement. As an effect, the leading pharmacists of the state called a meeting of the druggists of Indiana, to be held in Indianapolis on Tuesday, May 9, 1882. Among the reasons for the organization was the concerted support by the profession of "... Pharmacy Laws, regulating the profession. We need [said these leading pharmacists] all these adjuncts in this state, tending to elevate our business."

When it was learned that there was much interest throughout the state in the proposed organization, the druggists of Indianapolis set about to receive the convention. Hotel rates and train fares were

(34) *The Indiana Pharmacist*, n.s., 20, 348 (1938).

(35) *The Indiana Pharmacist*, n.s., 21, 8 (1939).

(36) Personal correspondence with J. Glenn Radcliffe, March 23, 1948.

(37) *The Indiana Pharmacist*, n.s., 21, 76 (1939).

(38) *The Indiana Pharmacist*, n.s., 13, No. 6, 42 (1931).

(39) Personal correspondence with Dean E. H. Niles, 1948.

(40) *The Indiana Pharmacist*, o.s., 1, No. 4, 6 (1882).

(41) *The Indiana Pharmacist*, o.s., 1, No. 12 (?), 5 (1883).

(42) *The Indiana Pharmacist*, o.s., 2, 191 (1883).

(43) *Ibid*, 287.

(44) *Ibid*, 320.

(45) *The Indiana Pharmacist*, o.s., 3, 13 (1884).

(46) *The Indiana Pharmacist*, o.s., 4, 332 (1886).

(47) *The Indiana Pharmacist*, o.s., 6, 304 (1888).

reduced for the benefit of the delegates. The Masonic Hall was scheduled as the meeting place, where, as planned, the Indiana Pharmaceutical Association was organized, May 9, 1882. The association was later incorporated under the laws of the state, December 13, 1885.⁴⁸ Among the outstanding men in the Indiana pharmacy who were registered at the first convention were William C. Buntin, Col. Eli Lilly, George W. Sloan, John N. Hurty, William H. Armstrong, Leo Eliel, Josiah K. Lilly, and Jos. R. Perry.⁴⁹

In the matter of membership, the question was raised as to whether other than retail druggists should be included. It was pointed out that the medical men were organized and that the wholesalers had had their convention without the retailers. It was the general feeling, however, that all who had the interest of the drug business at heart and who had met the requirement as thorough pharmacists should be included.

The fortunes of the Indiana Pharmaceutical Association over the period of sixty-six years have been varied. The offices of the association were maintained at New Albany until 1938 when they were moved to Indianapolis.⁵⁰ At one time (1893) the finances were in such a state that the proceedings of the convention could not be published.⁵¹ Disinterest and dissatisfaction of some members, heavy arguments, lack of funds, all have plagued the organization at times. The enthusiasm of the founders has returned in waves, however, and periods of depression have been followed by times wherein commendable advances have been made. It is interesting to note that some of the papers read before the early meetings of the association and published in *The Indiana Pharmacist* were translated into European journals and published without crediting the Hoosier authors, only to be brought back into other American periodicals as choice foreign articles.⁵² The association has survived even attacks of the elements (the flood of 1937 destroyed many of the old records at New Albany), and it is still the chief representation of the druggists of Indiana.

The Pharmacy Law

As a result of the regulation-free practice of pharmacy in Indiana, persons who failed to pass the examinations required in neighboring states poured into Indiana and took up practice here. The state became a "dumping ground for pharmaceutical charlatans." The influx substantially added to the number of ignorant and unethical druggists who strongly opposed any curbing of their nefarious interests.

From the founding of the association, the active members busied themselves with the problem of securing for the state a good pharmacy law. They drafted bills and pleaded for their support. The

adoption of the Medical Law of Indiana by the 1885 Legislature added fuel to the fires of enthusiasm, especially since the same body defeated a proposed pharmacy law.^{53, 54}

But the association refused to go down in defeat. A new bill was drafted. Joseph R. Perry's editorial support was thrown into the balance. A thousand copies of the proposed bill were printed to be distributed to the druggists and other interested people. Prominent pharmacists of the state wrote articles supporting the provisions of the law which required that all applicants be examined. William C. Buntin from Terre Haute,⁵⁵ August Detze and George H. Loesch of Fort Wayne,^{56, 57} Leo Eliel in South Bend^{58, 59} wrote at some length their pleas for support of the bill by the druggists of the state. The draft of the new law was submitted for approval to the law firm of Harrison, Hines, and Miller who pronounced it better than those of Ohio, Illinois, and Missouri. (Mr. Harrison we now know better in his capacity of President of the United States, 1889-1893.)

On the other hand, the opposition became active. A petition against any pharmacy legislation was signed by several hundred druggists and circulated.⁶⁰ A campaign of confusion was introduced by this faction and it, coupled with the disinterest of the other druggists, killed the law in the Legislature, 1889.

And so it went. In 1893, Joseph R. Perry, still acting as first editor of *The Indiana Pharmacist*, completely reversed his fifteen year old supportive policy and used that journal for vitriolic editorial attacks on pharmacy laws. Despite his newly taken opposition, however, Perry published articles and letters urging pharmaceutical legislation and pleading for compromise on touchy questions. There was still left enough interest to press the Legislature further for action, and in 1899, a law was enacted creating the Board of Pharmacy and providing for the registration of all who were then engaged in the practice of pharmacy.⁶¹

THE BOARD OF PHARMACY

Governor James A. Mount allowed the Pharmacy Law to become law without his signature. On May 1, following its enactment, Governor Mount appointed Indiana's first Board of Pharmacy. The membership⁶² of the first board included:

Charles P. Woodworth, Fort Wayne, president;
Charles Crecelius, New Albany, secretary;
Harry E. Glick, Lafayette;
Theodore E. Otto, Columbus;
George W. Sloan, Indianapolis.

(48) *The Indiana Pharmacist*, o.s., 4, 281 (1886).

(49) *The Indiana Pharmacist*, n.s., 13, No. 6, 17 (1931).

(50) Personal correspondence with H. V. Darnell, December 30, 1947.

(51) *The Indiana Pharmacist*, o.s., 12, 215 (1893).

(52) *The Indiana Pharmacist*, n.s., 13, No. 7, 10 (1931).

(53) *The Indiana Pharmacist*, o.s., 3, 325 (1885).

(54) *The Indiana Pharmacist*, o.s., 4, 102 (1885).

(55) *Ibid*, 104.

(56) *The Indiana Pharmacist*, o.s., 7, 9 (1888).

(57) *The Indiana Pharmacist*, o.s., 4, 107 (1885).

(58) *The Indiana Pharmacist*, o.s., 5, 294 (1887).

(59) *The Indiana Pharmacist*, o.s., 6, 137 (1887).

(60) *The Indiana Pharmacist*, o.s., 5, 357 (1887).

(61) *The Indiana Pharmacist*, n.s., 13, No. 6, 17 (1931).

(62) Personal correspondence with H. V. Darnell, January 14, 1948.

The law provided for the registration of those engaged in pharmacy at the time the law was enacted. The first work of the Board consisted of issuing 4,214 registers on application from those pharmacists in the business at that time. These certificates were issued upon the evidence of being actively engaged in the practice of pharmacy. Registered Pharmacist Certificate number one was issued to Bruno Knoefel of New Albany on July 1, 1899.⁶² (This memento is now framed and hangs in the office of the Indiana Pharmaceutical Association in Indianapolis.) Since its creation the Board of Pharmacy has held examinations for registration and awarded certificates of registration for pharmacists and assistant pharmacists.

At following sessions of the Legislature laws were enacted to regulate the sale of certain drugs and vesting more power in the Board of Pharmacy. In 1925, the Legislature provided for an Inspector to be employed by the Board to see that the drug laws were enforced.⁶¹ The present drug store permit law was passed in 1927. It provides for the registration of pharmacies and stores engaged in the pharmacy business. It limits the use of such titles and terms as drugs, drug stores, pharmacies, etc., to registered establishments. The Indiana Board of Pharmacy is given the power to enforce the provisions of this law and impose penalties for its violation.

The present Uniform Narcotics Drug Act of 1935 is patterned very much after the Harrison Narcotic Act, and the Indiana Food, Drug, and Cosmetic Act of 1939 is very similar to the Federal Food, Drug, and Cosmetic Act; both of these laws are so designed with the intention of bringing the state regulations in as close conformity to those of the national government as possible.

The elimination of undesirable practitioners by supervised, comprehensive examination is a practice common to most professions today. It is chiefly by such regulation and enforcement of good laws that the profession of pharmacy can maintain its high standards of service to the public and to its sister medical professions.

THE BOARD OF HEALTH

Quite apart from and antedating by several years the Indiana Board of Pharmacy (1899), is the Indiana State Board of Health, authorized by state law, March 7, 1881. Probably the greatest contribution of the profession of pharmacy to this phase of medicine is embodied in the figure of a man, John N. Hurty, who began a long and very active career in public health as a pharmacist.

Col. Eli Lilly "beguiled" him into the drug business. As a youth of about seventeen, he began working for the Colonel in his Paris, Illinois, Red Front Drug Store. As an apprentice he was given the job of sweeping floors, washing glassware, rolling pills after they had been properly compounded, unpacking and shelving stock, and similar duties. Later his responsibilities increased and, as he learned more about the subject of pharmacy, he realized that he would need a sound basic educa-

tion. In 1871, he enrolled in the Philadelphia College of Pharmacy and Science, where he studied for a year; however, he did not graduate.

Back in Paris, he resumed his work at the Red Front Store. But in 1873, Col. Lilly sold his interest in the store and went into partnership with Dr. John C. Johnston of Indianapolis, making pharmaceuticals there. He took with him young Hurty as "foreman of the pharmaceutical works." When the Johnston-Lilly partnership was dissolved, Hurty bought a drug store in Indianapolis, which built up a sizeable clientele among those doctors and patients familiar with the excellent quality of Hurty prescriptions.

It was while he was operating this store that he received both an honorary and a genuine M.D. degree. It was in this store, one day in 1883, that Dr. James H. Smart, president of Purdue University, secured Dr. Hurty's promise to accept the chair in pharmacy, if a pharmacy school were established at Purdue. It was from this store also that, through professorships, his influence emanated to two other prominent Indiana schools, the Medical College of Indiana and the Indiana Dental College. It was from this store, finally, that he went to assume the duties of secretary of the Indiana State Board of Health on March 12, 1896, in which capacity he became most famous.

As Dr. Hurty the sanitarian and chemist came more and more into prominence, it was necessary for him to get someone to care for his drug store, and gradually, he sold his interest to the man who managed it for him for several years. But to the end of his life Dr. Hurty retained his interest in and love for pharmacy.⁶³

The history of pharmacy in Indiana has witnessed the passing of the individualist who collected initial materials and processed them into finished medicines and his replacement in large measure by the manufacturer using mass production methods. Transition has been accompanied by the application of science through intensive research and control. The making of medicines now requires the teamwork of many specialists, such as scientists, engineers, and purchasing, production, and sales specialists. Insulin, the sulfa drugs, penicillin and streptomycin are examples of drugs that this cooperative effort have brought to the services of the public. While the pharmaceutical and medical professions play an important role in the making of medicines, their separate roles remain the same as they have been in the past: the physician serving to diagnose diseases and prescribe medicines, and the pharmacist serving to compound and dispense the drugs that have proven so effective against many of the diseases of mankind.

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The authors are indebted to many persons for their assistance in furnishing information for this chapter, particularly to John S. Wright for source material and extensive abstracts.

(63) Rice, Thurman B., *The Hoosier Health Officer*, n.p., 1939-1946, p. 17.

The DOCTOR

James Whitcomb Riley



We may idealize the chief of men—
Idealize the humblest citizen,—
Idealize the ruler in his chair—
The poor man, or the poorer millionaire;
Idealize the soldier—sailor—or
The simple man of peace—at war with war;—
The hero of the sword or fife-and-drum. . . .
Why not idealize the Doctor some?

The Doctor is, by principle, we know,
Opposed to sentiment. He veils all show
Of feeling, and is proudest when he hides
The sympathy which natively abides.
Within the stoic precincts of a soul
Which owes strict duty as its first control,
And so must guard the ill, lest worse may come . .
Why not idealize the Doctor some?

He wisely hides his heart from you and me—
He hath grown tearless, of necessity,—
He knows the sight is clearer, being blind;
He knows the cruel knife is very kind;
Ofttimes he must be pitiless, for thought
Of the remembered wife or child he sought
To save through kindness that was overcome.
Why not idealize the Doctor some?

He is the master of emotions—he
Is likewise certain of that mastery,—
Or dare he face contagion in its ire,
Or scathing fever in its leaping fire?
He needs must smile upon the ghastly face
That yearns up toward him in that warded place
Where even the Saint-like Sisters' lips grow dumb.
Why not idealize the Doctor some?

Bear with him, trustful, in his darkest doubt
Of how the mystery of death comes out;
He knows—he knows,—ay, better yet than we,
That out of Time must dawn Eternity;
He knows his own compassion—what he would
Give in relief of all ills, if he could,—
We wait alike one Master: He will come.
Do we idealize the Doctor some?



From "Morning" by James Whitcomb Riley, copyright 1907.
Used by special permission of the publishers, The Bobbs-Merrill Company.

THE year 1949 marks the 100th anniversary of the birth of James Whitcomb Riley, as well as the Indiana State Medical Association. The Hoosier poet was a devoted friend of medicine, and gave lyrical praise to doctors on many occasions. He came by it naturally, however, for his father, while an attorney by profession, was noted among his neighbors for his skill and interest in old-fashioned remedies.

One of the greatest poetical tributes ever paid to the healing profession is Mr. Riley's poem, "The Doctor," written upon the death of Dr. William B. Fletcher, an Indianapolis physician, in 1907. Another tribute to doctors is Mr. Riley's "Doc Sifers," founded on the author's observation of many country doctors. "Doc Sifers" did not exist in actual life.

Presidents
of the
Indiana State Medical Association



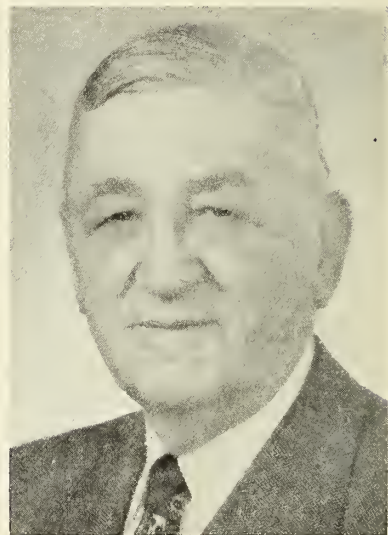
1849-1949



DR. HAUSS

The Centennial Year President

Dr. Augustus P. Hauss of New Albany had the distinct honor of serving as president during the Centennial Year. Born in Indiana in 1888, he is a graduate of the University of Louisville School of Medicine. The 100th president presided at the Indianapolis session in 1949.



DR. BLACK

First President in Second Century

President of the state association as it begins its second century will be Dr. Claude S. Black of Warren, who was president-elect in 1949. He will preside at the French Lick session in 1950. Doctor Black was born in Indiana in 1880 and is a graduate of the Medical College of Indiana.

Five Elected President, But Did Not Preside

Death or illness prevented five physicians elected to the presidency of the Indiana State Medical Association from serving. They were:

John Sloan of New Albany, 1815-1898. Fifteenth president, but did not preside on account of illness. Born in Maine. Graduate of Bowdoin Medical College.

Samuel L. Linton of Columbus, 1809-1889. Sixteenth president, but did not preside on account of illness. Born in Ohio. Graduate of Ohio Medical College.

Isaac Casselberry of Evansville, 1821-1873. Twenty-fifth president, but died soon after his election. Born in Indiana. Graduate of Ohio Medical College.

Louis Humphreys of South Bend, 1816-1880. Thirtieth president, but resigned on account of illness. Born in Ohio. Graduate of Ohio Medical College.

Elijah S. Elder of Indianapolis, 1841-1894. Forty-sixth president, but died the next day after he was elected. Born in Indiana. Graduate of Ohio Medical College.



DR. SLOAN



DR. LINTON



DR. CASSELBERRY



DR. HUMPHREYS

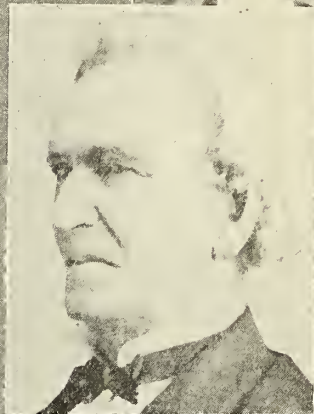


DR. ELDER

LIVINGSTON DUNLAP of Indianapolis, 1799-1862
President of the convention at Indianapolis 1849.
Born in New York. Graduate of Transylvania Medical College.



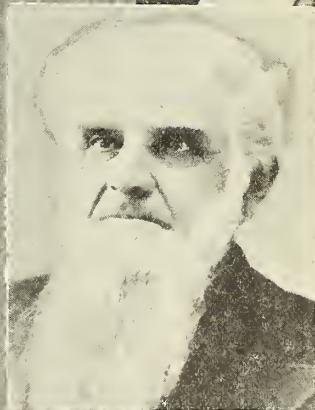
WILLIAM T. S. CORNETT of Versailles, 1805-1897
First president at Indianapolis Session 1850. Born in
Kentucky. Graduate of Transylvania Medical College.



ASHAHEL CLAPP of New Albany, 1792-1862
Second president at Indianapolis Session 1851. Born
in Massachusetts. Not a graduate. Read medicine
under a preceptor in Vermont. An internationally
known botanist and geologist.

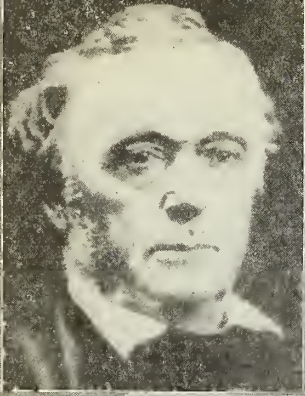


GEORGE W. MEARS of Indianapolis, 1803-1879
Third president at New Albany Session 1852. Born
in Pennsylvania. Graduate of Jefferson Medical Col-
lege.



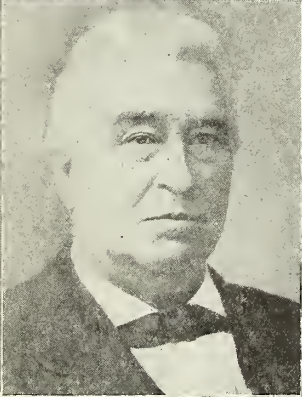
JEREMIAH H. BROWER of Lawrenceburg, 1798-1866
Fourth president at Lafayette Session 1853. Born in
New York. Never graduated, studied with his father.





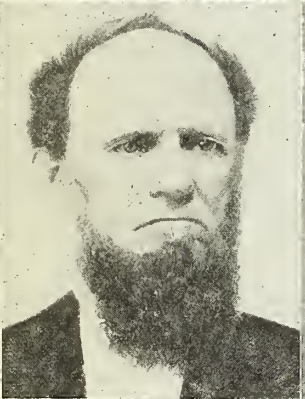
ELIZUR H. DEMING of Lafayette, 1797-1855

Fifth president at Evansville Session 1854. Born in Massachusetts. Graduate of Williamstown Massachusetts Medical College.



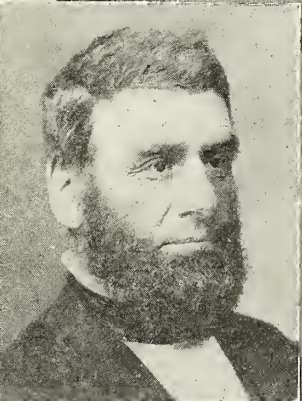
MADISON J. BRAY of Evansville, 1811-1900

Sixth president at Indianapolis Session 1855. Born in Maine. Graduate of Bowdoin Medical College.



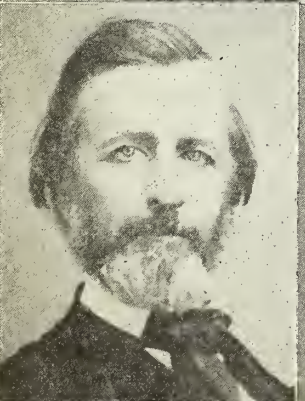
WILLIAM LOMAX of Marion, 1813-1893

Seventh president at Indianapolis Session 1856. Born in North Carolina. Graduate of Medical College of New York.



DANIEL MEEKER of LaPorte, 1806-1876

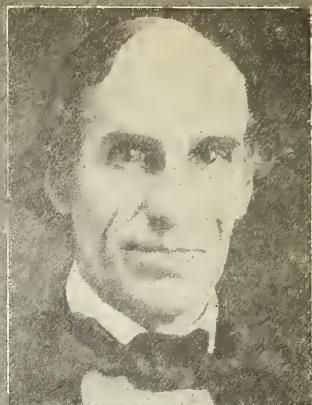
Eighth president at Indianapolis Session 1857. Born in New York. Graduate of Ohio Medical College.



TALBOT BULLARD of Indianapolis, 1815-1863

Ninth president at Indianapolis Session 1858. Born in Massachusetts. Graduate of Ohio Medical College.

NATHAN JOHNSON of Cambridge City, 1794-1872
Tenth president at Indianapolis Session 1859. Born in Virginia. Graduate of Jefferson Medical College.



DAVID HUTCHINSON of Mooresville, 1812-1891
Eleventh president at Indianapolis Session 1860. Born in Scotland. Graduate of Ohio Medical College.



BENJAMIN S. WOODWORTH of Ft. Wayne, 1816-1891
Twelfth president at Indianapolis Session 1861. Born in Massachusetts. Graduate of Berkshire Medical College, Pittsfield, Mass.

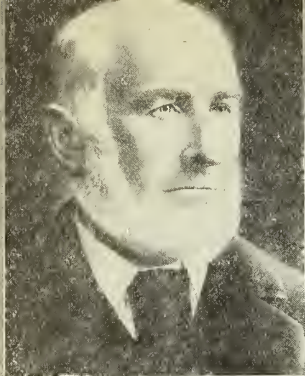


THEOPHILUS PARVIN of Indianapolis, 1829-1899
Thirteenth president at Indianapolis Session 1862. (Youngest president, age 33.) Born in Buenos Aires, South America. Graduate of University of Pennsylvania Medical College. Professor of Gynecology and Obstetrics, Jefferson Medical College. President of American Medical Association in 1879.



JAMES F. HIBBERD of Richmond, 1816-1903
Fourteenth president at Indianapolis Session 1863. Born in Maryland. Graduate of College of Physicians and Surgeons, Columbia University, N. Y. President of American Medical Association in 1894.





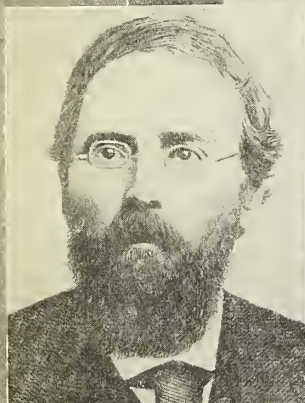
JOHN MOFFETT of Rushville, 1822-1903

Vice-president acting as president at Indianapolis Session 1864. Born in Virginia. Graduate of Ohio Medical College.



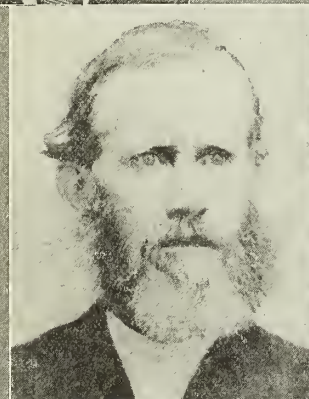
WILSON LOCKHART of Danville, 1825-1910

Vice-president acting as president at Richmond Session 1865. Graduate of Jefferson Medical College.



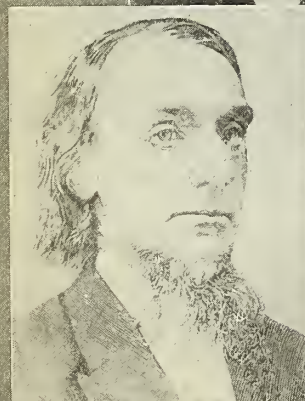
MYRON H. HARDING of Lawrenceburg, 1810-1883

Seventeenth president at Indianapolis Session 1866. Born in New York. Graduate of Ohio Medical College.



VIERLING KERSEY of Richmond, 1809-1875

Eighteenth president at Indianapolis Session 1867. Born in North Carolina. Graduate of Ohio Medical College.



JOHN S. BOBBS of Indianapolis, 1809-1870

Nineteenth president at Indianapolis Session 1868. Born in Pennsylvania. Graduate of Jefferson Medical College. The father of Cholecystotomy.

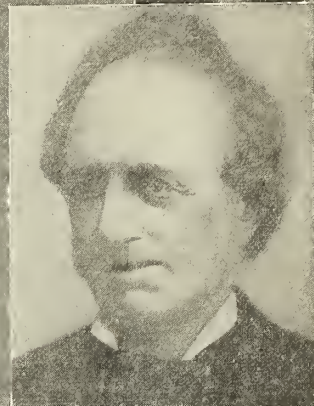
NATHANIEL FIELD of Jeffersonville, 1805-1888

Twentieth president at Indianapolis Session 1869. Born in Kentucky. Graduate of Transylvania Medical College.



GEORGE SUTTON of Aurora, 1812-1886

Twenty-first president at Indianapolis Session 1870. Born in England. Graduate of Ohio Medical College.



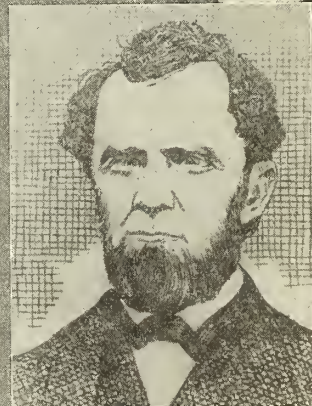
ROBERT N. TODD of Indianapolis, 1827-1883

Twenty-second president at Indianapolis Session 1871. Born in Kentucky. Graduate of Indiana Central Medical College. The first Indiana graduate to be president.



HENRY P. AYRES of Ft. Wayne, 1813-1887

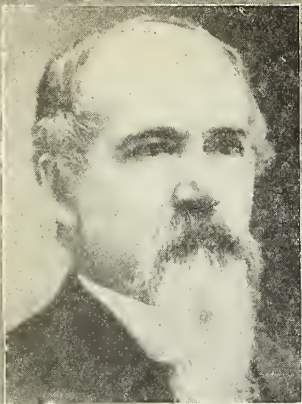
Twenty-third president at Indianapolis Session 1872. Born in New Jersey. Graduate of University of New York Medical College.



JOEL PENNINGTON of Milton, 1799-1887

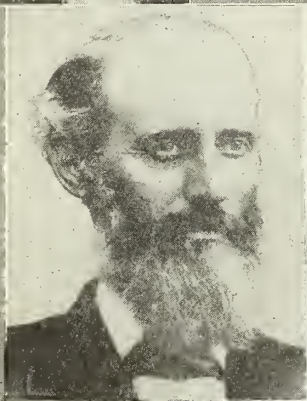
Twenty-fourth president at Indianapolis Session 1873. Born in Pennsylvania. Graduate of Ohio Medical College. Oldest president, age 74 when elected.





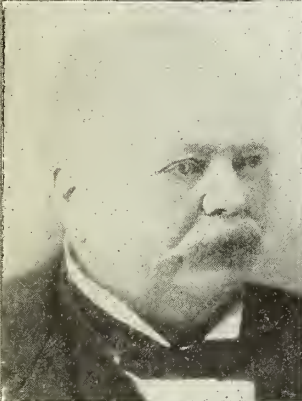
WILSON HOBBS of Knightstown, 1823-1892

Vice-president acting as president at Indianapolis Session 1874. Born in Indiana. Graduate of Cincinnati College of Medicine and Surgery.



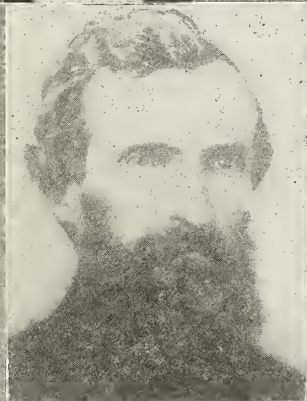
RICHARD E. HAUGHTON of Richmond 1827-1909

Twenty-sixth president at Indianapolis Session 1875. Born in Indiana. Graduate of Western Reserve Medical College.



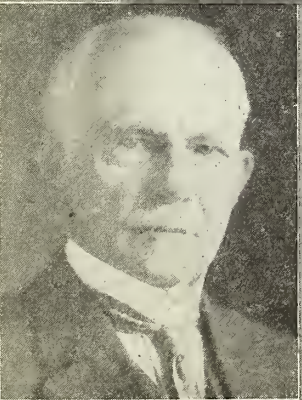
JOHN H. HELM of Peru, 1826-1899

Twenty-seventh president at Indianapolis Session 1876. Born in Tennessee. Graduate of Ohio Medical College.



SAMUEL S. BOYD of Dublin, 1820-1888

Twenty-eighth president at Indianapolis Session 1877. Born in Indiana. Graduate of Ohio Medical College.

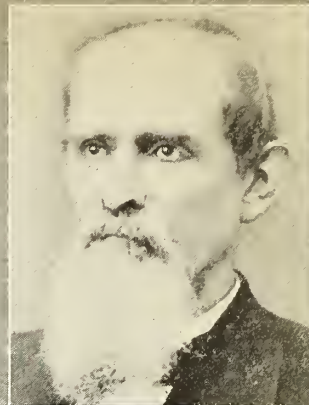


LUTHER D. WATERMAN of Indianapolis, 1813-1918

Twenty-ninth president at Indianapolis Session 1878. Born in West Virginia. Graduate of Ohio Medical College.

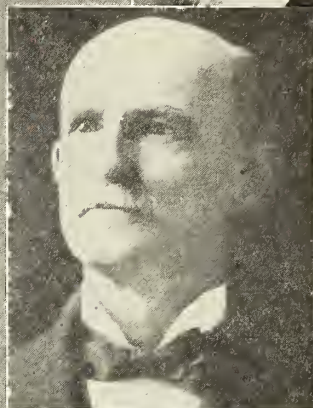
BENJAMIN NEWLAND of Bedford, 1821-1889

Vice-president acting as president at Indianapolis Session 1879. Born in Indiana. Graduate of University of Louisville.



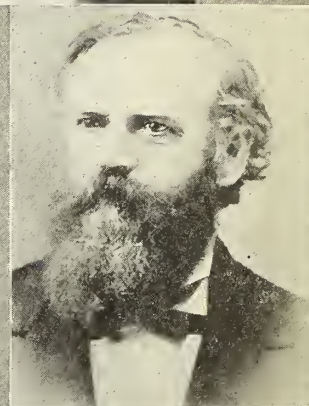
JACOB R. WEIST of Richmond 1834-1900

Thirty-first president at Indianapolis Session 1880. Born in Ohio. Graduate of Jefferson Medical College.



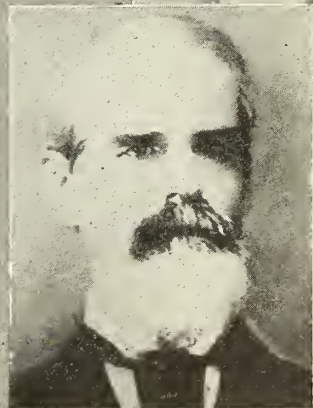
THOMAS B. HARVEY of Indianapolis 1827-1889

Thirty-second president at Indianapolis Session 1881. Born in Ohio. Graduate of Ohio Medical College.



MARSHALL SEXTON of Rushville, 1823-1892

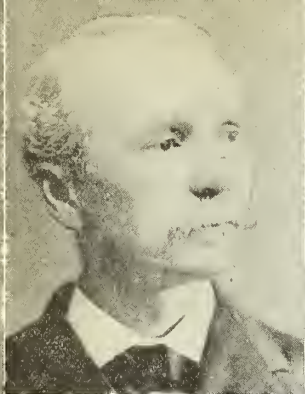
Thirty-third president at Indianapolis Session 1882. Born in Indiana. Graduate of Ohio Medical College.



WILLIAM H. BELL of Logansport, 1839-1911

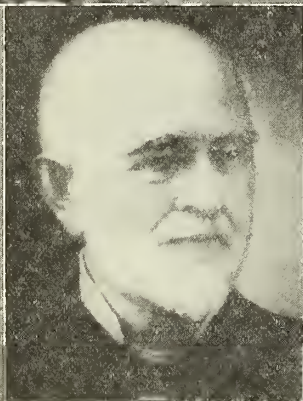
Thirty-fourth president at Indianapolis Session 1883. Born in New Jersey. Graduate of University of Toronto.





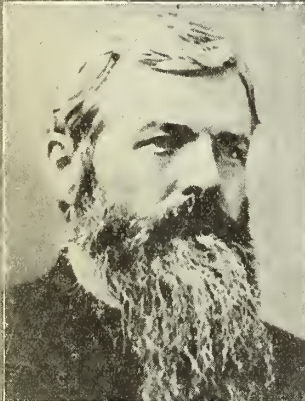
SAMUEL E. MUNFORD of Princeton, 1837-1893

Thirty-fifth president at Indianapolis Session 1884.
Born in Indiana. Graduate of Jefferson Medical College.



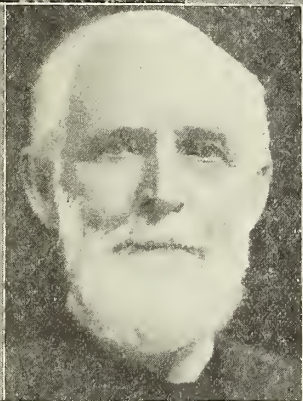
JAMES H. WOODBURN of Indianapolis, 1822-1901

Thirty-sixth president at Indianapolis Session 1885.
Born in Indiana. Graduate of University of Louisville.



JAMES S. GREGG of Ft. Wayne, 1830-1890

Thirty-seventh president at Indianapolis Session 1886.
Born in Pennsylvania. Graduate of Jefferson Medical College.



GENERAL W. H. KEMPER of Muncie, 1839-1927

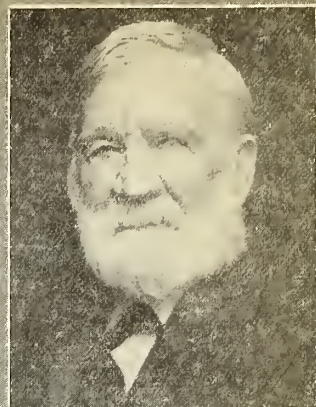
Thirty-eighth president at Indianapolis Session 1887.
Born in Indiana. Graduate of Long Island College Hospital.



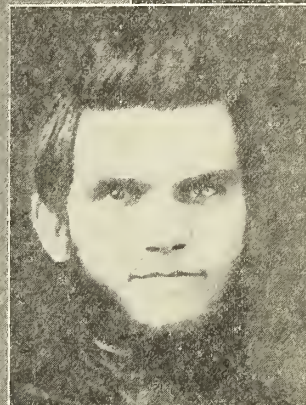
SAMUEL H. CHARLTON of Seymour, 1826-1897

Thirty-ninth president at Indianapolis Session 1888.
Born in Indiana. Practiced 21 years before finally graduating from Louisville Medical College.

WILLIAM H. WISHARD of Indianapolis, 1816-1913
Fortieth president at Indianapolis Session 1889. Born in Kentucky. Graduate of LaPorte (Indiana) Medical College. Last survivor of the 1849 Convention.



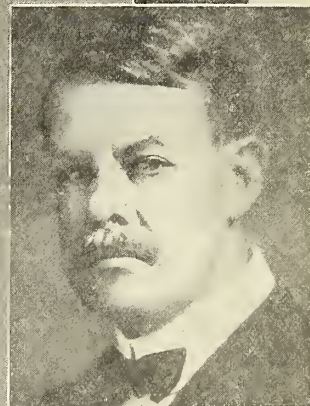
JAMES D. GATCH of Lawrenceburg, 1831-1907
Forty-first president at Indianapolis Session 1890. Born in Ohio. Graduate of Ohio Medical College.



GONSOLVO C. SMYTHE of Greencastle, 1836-1897
Forty-second president at Indianapolis Session 1891. Born in Indiana. Graduate of Rush Medical College.



EDWIN WALKER of Evansville, 1853-1922
Forty-third president at Indianapolis Session 1892. Born in Indiana. Graduate of Evansville Medical College.



GEORGE F. BEASLEY of Lafayette, 1841-1931
Forty-fourth president at Indianapolis Session 1893. Born in Indiana. Graduate of Rush Medical College.





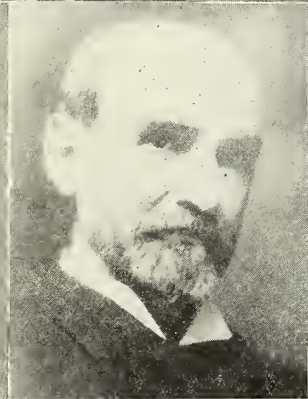
CHARLES A. DAUGHERTY of South Bend, 1850-1913
Forty-fifth president at Indianapolis Session 1894.
Born in Ohio. Graduate of Bennett Medical College,
Chicago.



CHARLES S. BOND of Richmond, 1856-
Vice-president acting as president at Indianapolis Ses-
sion 1895. Born in Indiana. Graduate of Bellevue
Medical College.



MILES F. PORTER of Ft. Wayne, 1856-1933
Forty-seventh president at Ft. Wayne Session 1896.
Born in Indiana. Graduate of Ohio Medical College.



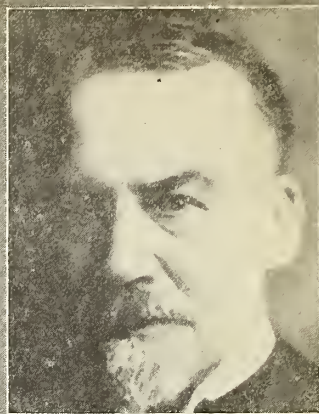
JAMES H. FORD of Indianapolis, 1848-1915
Forty-eighth president at Terre Haute Session 1897.
Born in Indiana. Graduate of University of Michigan.



WILLIAM N. WISHARD, SR., of Indianapolis, 1851-1941
Forty-ninth president at Lafayette Session 1898. Born
in Indiana. Graduate of Indiana Medical College.

JOHN C. SEXTON of Rushville, 1859-1936

Fiftieth president at Indianapolis Session 1899. Born in Indiana. Graduate of Ohio Medical College.



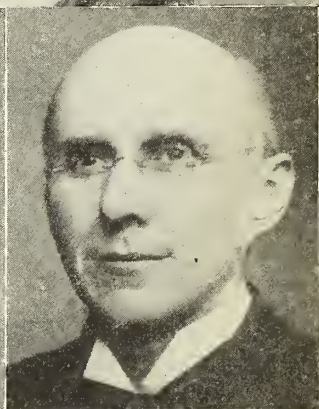
WALKER SCHELL of Terre Haute, 1857-1915

Fifty-first president at Anderson Session 1900. Born in Indiana. Graduate of Miami Medical College.



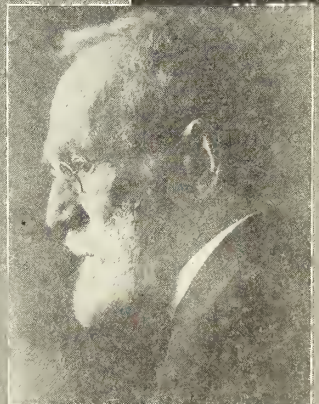
GEORGE W. MCCASKEY of Ft. Wayne, 1853-1935

Fifty-second president at South Bend Session 1901. Born in Ohio. Graduate of Jefferson Medical College.



ALEMBERT W. BRAYTON of Indianapolis, 1848-1927

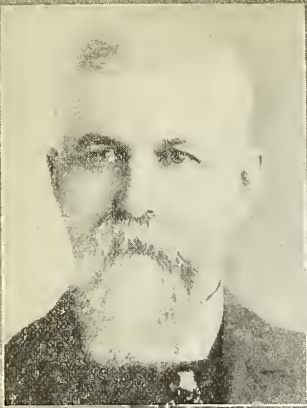
Fifty-third president at Evansville 1902. Born in New York. Graduate of Indiana Medical College.



JOHN B. BERTELING of South Bend, 1860-1940

Fifty-fourth president at Richmond Session 1903. Born in Ohio. Graduate of Miami Medical College.





JONAS STEWART of Anderson, 1843-1926

Fifty-fifth president at Indianapolis Session 1904.
Born in Indiana. Graduate of Long Island College
Hospital.



GEORGE T. MACCOY of Columbus, 1846-1930

Fifty-sixth president at West Baden Session 1905.
Born in Indiana. Graduate of Miami Medical College.



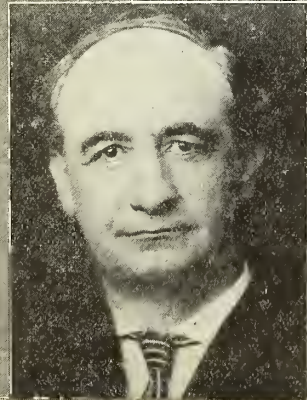
GEORGE H. GRANT of Richmond, 1868-1908

Fifty-seventh president at Winona Lake Session 1906.
Born in Indiana. Graduate of Rush Medical College



GEORGE J. COOK of Indianapolis, 1844-1916

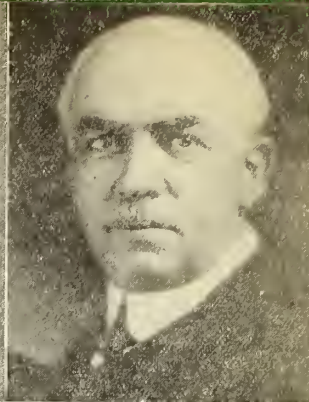
Fifty-eighth president at Indianapolis Session 1907.
Born in Pennsylvania. Graduate of Kentucky School
of Medicine.



DAVID C. PEYTON of Jeffersonville, 1860-1923

Fifty-ninth president at French Lick Session 1908.
Born in Indiana. Graduate of University of Louisville.

GEORGE D. KAHLO of French Lick, 1864-1916
Sixtieth president at Terre Haute Session 1909. Born
in Ohio. Graduate of Bellevue Medical College.



THOMAS C. KENNEDY of Shelbyville, 1862-1928
Sixty-first president at Ft. Wayne 1910. Born in In-
diana. Graduate of Kentucky School of Medicine.



FREDERICK C. HEATH of Indianapolis, 1857-1918
Sixty-second president at Indianapolis Session 1911.
Born in Maine. Graduate of Bowdoin Medical College.



WILLIAM F. HOWAT of Hammond, 1869-1929
Sixty-third president at Indianapolis Session 1912.
Born in Canada. Graduate of University of Pennsyl-
vania.



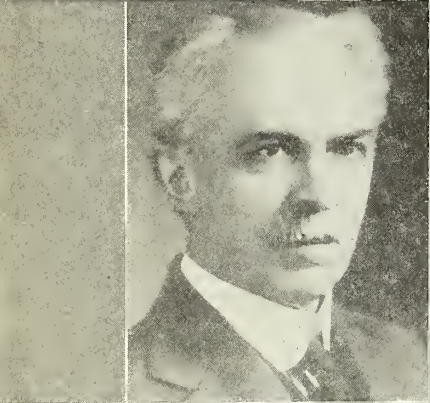
ALBERT C. KIMBERLIN of Indianapolis, 1863-1921
Sixty-fourth president at West Baden Session 1913.
Born in Indiana. Graduate of Indiana Medical Col-
lege.





JOHN P. SALB of Jasper, 1855-1925

Sixty-fifth president at Lafayette Session 1914. Born in Ohio. Graduate of Indiana Medical College.



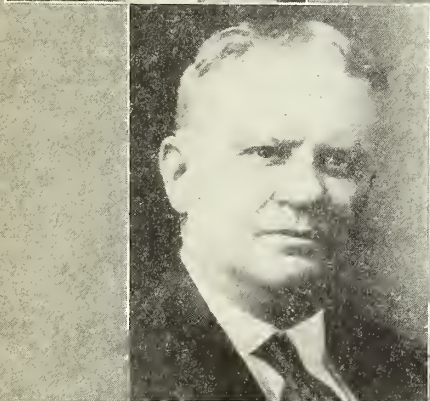
FRANK B. WYNN of Indianapolis, 1860-1922

Sixty-sixth president at Indianapolis Session 1915. Born in Indiana. Graduate of Miami Medical College.



GEORGE F. KEIPER of Lafayette, 1866-1928

Sixty-seventh president at Ft. Wayne Session 1916. Born in Indiana. Graduate of University of Michigan.



JOHN H. OLIVER of Indianapolis, 1859-1927

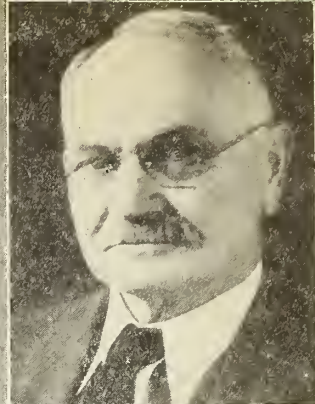
Sixty-eighth president at Evansville Session 1917. Born in Indiana. Graduate of Medical College of Indiana.



J. RILUS EASTMAN of Indianapolis, 1871-1942

Sixty-ninth president at Indianapolis Session 1918. Born in Indiana. Graduate of University of Berlin.

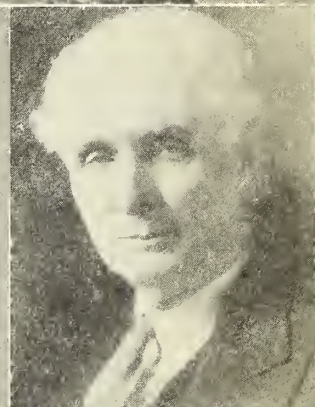
WILLIAM H. STEMM of North Vernon, 1861-
Seventieth president at Indianapolis Session 1919
Born in Maryland. Graduate of Ohio Medical College.



CHARLES H. MCCULLY of Logansport, 1868-1941
Seventy-first president at South Bend Session 1920.
Born in Indiana. Graduate of Eclectic Medical College,
Cincinnati.



DAVID ROSS of Indianapolis, 1865-1931
Seventy-second president at Indianapolis Session 1921.
Born in Indiana. Graduate of Medical College of
Indiana.



WILLIAM R. DAVIDSON of Evansville, 1875-
Seventy-third president at Muncie Session 1922. Born
in Indiana. Graduate of Rush Medical College.



CHARLES H. GOOD of Huntington, 1860-1932
Seventy-fourth president at Terre Haute Session 1923.
Born in Indiana. Graduate of Rush Medical College.





SAMUEL E. EARP of Indianapolis, 1858-1930

Seventy-fifth president at Indianapolis Session 1924.
Born in Illinois. Graduate of Central College of
Physicians and Surgeons, Indianapolis.



ELDRIDGE M. SHANKLIN of Hammond, 1875-

Seventy-sixth president at Marion Session 1925. Born
in Indiana. Graduate of Medical College of Indiana.



CHARLES N. COMBS of Terre Haute, 1879-

Seventy-seventh president at West Baden Session in
1926. Born in Indiana. Graduate of Medical College
of Indiana.



FRANK W. CREGOR of Indianapolis, 1873-1942

Seventy-eighth president at Indianapolis Session 1927.
Born in Indiana. Graduate of Indiana Medical College.



GEORGE R. DANIELS of Marion, 1878-

Seventy-ninth president at Gary Session 1928. Born
in Indiana. Graduate of Medical College of Indiana.

CHARLES E. GILLESPIE of Seymour, 1877-

Eightieth president at Evansville Session 1929. Born in Indiana. Graduate of Central College of Physicians and Surgeons, Indianapolis.



ANGUS C. McDONALD of Warsaw, 1865-1944

Eighty-first president at Ft. Wayne Session 1930. Born in Canada. Graduate of University of Pennsylvania.



ALOIS B. GRAHAM of Indianapolis, 1870-1948

Eighty-second president at Indianapolis Session 1931. Born in Indiana. Graduate of Medical College of Indiana.



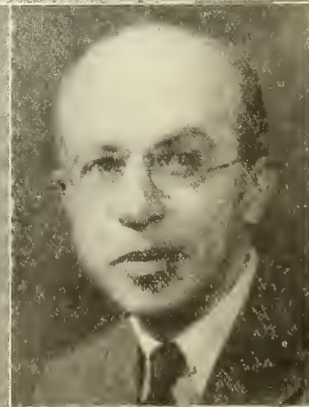
FRANKLIN S. CROCKETT of Lafayette, 1881-

Eighty-third president at Michigan City Session 1932. Born in Indiana. Graduate of Medical College of Indiana.



JOSEPH H. WEINSTEIN of Terre Haute, 1876-

Eighty-fourth president at French Lick Session 1933. Born in Illinois. Graduate of Miami Medical College.





EVERETT E. PADGETT of Indianapolis, 1878-
Eighty-fifth president at Indianapolis Session 1934.
Born in Indiana. Graduate of Rush Medical College.



WALTER J. LEACH of New Albany, 1862-1935
Eighty-sixth president, but died a few days before he
was to preside, at the Gary Session 1935. (President-
elect R. L. Sensenich presiding.) Born in Indiana.
Graduate of Louisville Medical College.



ROSCOE L. SENSENICH of South Bend, 1882-
Eighty-seventh president at the South Bend Session
1936. Born in Indiana. Graduate of Rush Medical
College. President, American Medical Association in
1948.

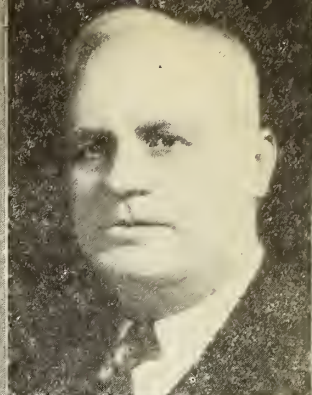


EDMUND D. CLARK of Indianapolis, 1869-1938
Eighty-eighth president at French Lick Session 1937.
Born in Indiana. Graduate of Bellevue Medical Col-
lege.



HERMAN M. BAKER of Evansville, 1889-
Eighty-ninth president at Indianapolis Session 1938.
Born in Kentucky. Graduate of Louisville University
Medical Department.

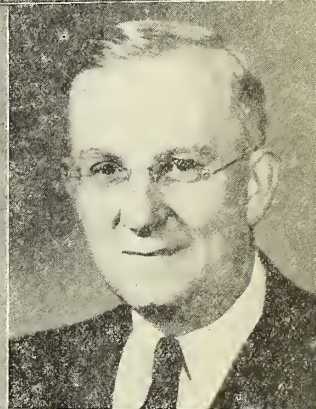
EDMUND M. VAN BUSKIRK of Ft. Wayne, 1875-
Ninetieth president at Ft. Wayne Session 1939. Born
in Indiana. Graduate of Fort Wayne College of Medi-
cine.



KARL R. RUDELL of Indianapolis, 1887-
Ninety-first president of French Lick Session 1940.
Born in Illinois. Graduate of Indiana University
School of Medicine.



ALBERT M. MITCHELL of Terre Haute, 1889-
Ninety-second president at Indianapolis Session 1941.
Born in Indiana. Graduate of University of Louisville
Medical Department.



MAYNARD A. AUSTIN of Anderson, 1876-
Ninety-third president at French Lick Session 1942.
Born in Indiana. Graduate of Rush Medical College.



CARL H. MCCASKEY of Indianapolis, 1877-
Ninety-fourth president at Indianapolis Session 1943.
Born in Indiana. Graduate of Indiana University
School of Medicine.





JACOB T. OLIPHANT of Farmersburg, 1880-
Ninety-fifth president at Indianapolis Session 1944.
Born in Indiana. Graduate of Medical College of
Indiana.



NESLEN K. FORSTER of Hammond, 1892-
Ninety-sixth president at French Lick Session 1945.
Born in Montana. Graduate of University of Illinois
Medical School.



JESSE E. FERRELL of Fortville, 1880-
Ninety-seventh president at Indianapolis Session 1946.
Born in Indiana. Graduate of Medical College of
Indiana.



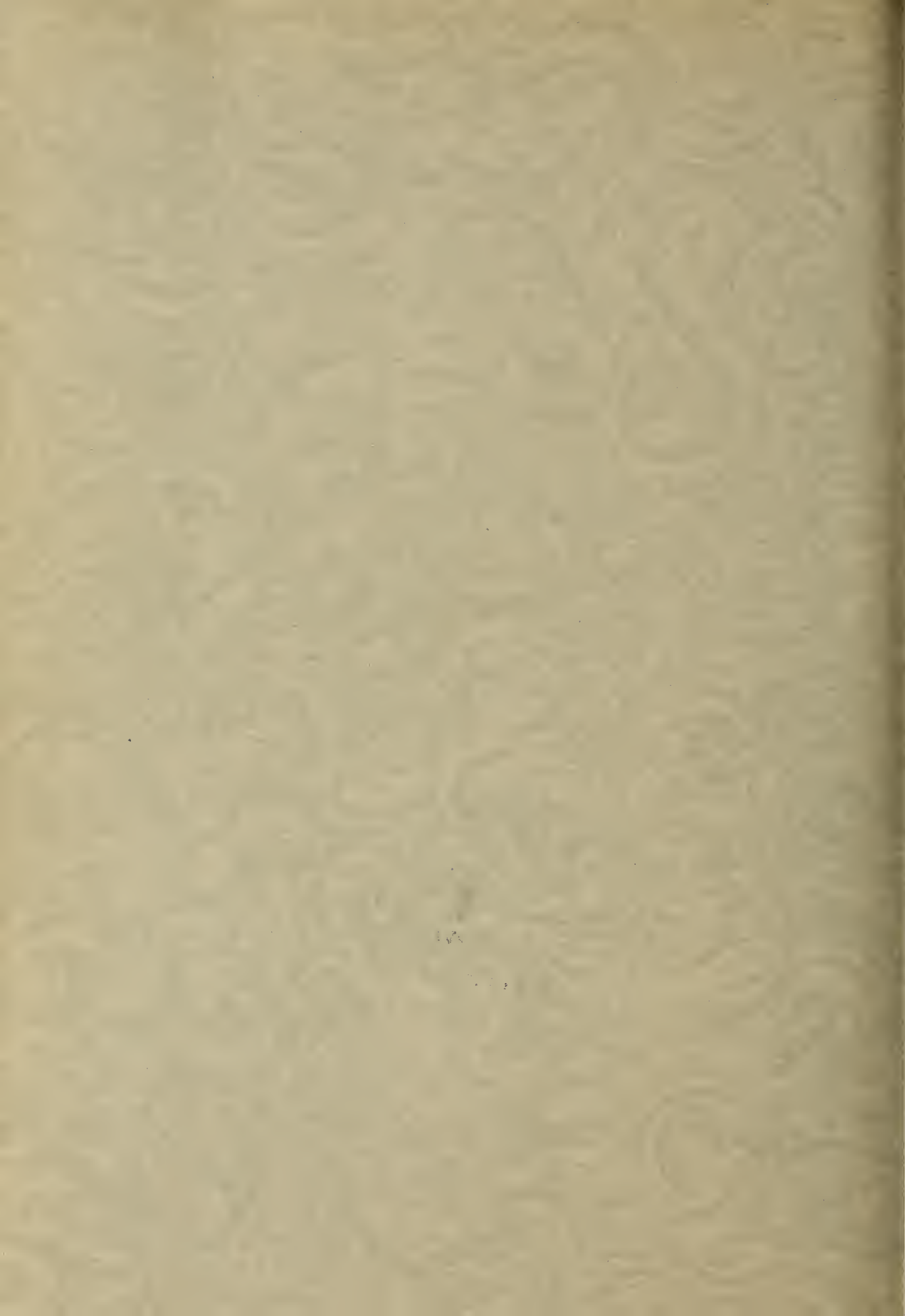
FLOYD T. ROMBERGER of Lafayette, 1887-
Ninety-eighth president at French Lick Session 1947.
Born in Pennsylvania. Graduate of University of
Pennsylvania School of Medicine.



CLEON A. NAFE of Indianapolis, 1892-
Ninety-ninth president of Indianapolis Session 1948.
Born in Indiana. Graduate of Indiana University
School of Medicine.







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